DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

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JILECTON,		
Initial di	s after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	20 to manufact on the contract and the contract of the contrac
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31. DATE FILED (Month, Day, 16

Gadsen,MD,

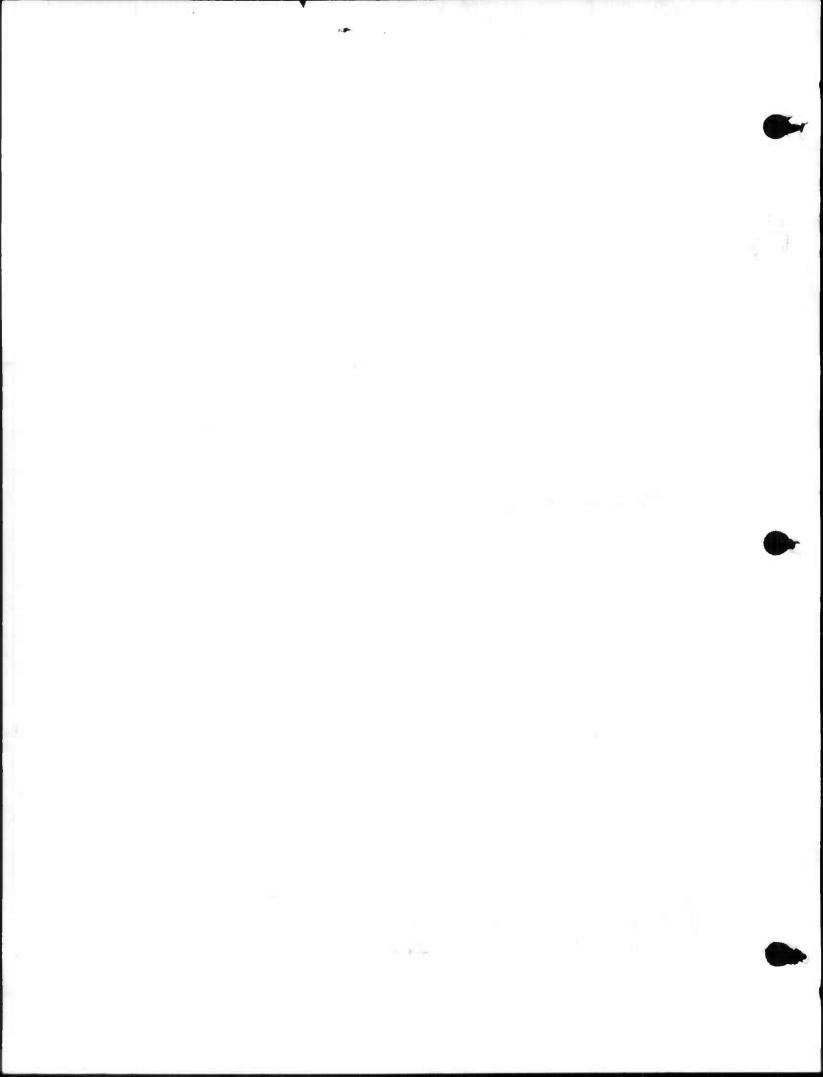
**"**93

	FOR 1 - STATE	STATE OF I	WARYLAND /						MENTAL	HYGIEN	IE.	33	09	20	1
Ī	REGISTRAR  1. DECEDENT'S NAME (First, Middle, Lust)  JOHN JOSE	PH F	ROGERS	RTIF	ICATI	E OF	DEAT	ГН	2. DATE O			YEAR 993	3. TIME 6	F DEATH	_
	4. SOCIAL SECURITY NUMBER 232-01-2535	5. SEX 1 ∑NA 2 ☐ F	8. AGE (In yrs. last	birthday) YRS.	IF UNDER	DAYS	IF UNDER HOURS	24 HRS. MIN.	7. DATE OF 10-24			8. BIRTI	HPLACE (St	ate or Foreig	gn
TOR	9a. FACILITY NAME (If not institution, give a Physicians Memor RESIDENCE OF DECEDENT		ital			lata	OR LOCATION	ON OF DE	EATH		oc. cou Char	les	DEATH		
DIRECTOR	4	rles			y, town o	ata							10d. INSII LIMI XIX YES	DE CITY TS? 2.1 NO	5
FUNERAL	100. STREET AND NUMBER 6123 Gray Wolf C							603				USA	WHAT COU	ITRY?	
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced		IT EVER IN U.S. ARM  YES Ž∕∑N WAR OR DATES			If yes, sp	ENDENT Of Cuba 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	n. Mexica	NIC ORIGIN? in, Puerto Ric y:	Specify Ver an, etc.)	or No—	Biac	E — Americ k, White, et L'L'C	an Indian, C.	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) Coffege (1-4 or 5	(Gh	n kind of Do NOT u	usual or work done se retired.)	during mo	st of workin	ng .	16b, K		SINESS/IND		ent		
BE CO	17. FATHER'S NAME (First, Middle, Lest) John Rogers						18. MOTE	Anna	ME (First, Mic a Balt	ınas	,				
5	Mary E. Rogers		196.	MAILING 123	Gray	/WO1	e Ct.	or Rural F	Route Number aldori	City or Tow Md	n, State, Zip • 206	03			
	20a. METHOD OF DISPOSITION 1 1 Surial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)		206. PLACE A cempetery, cren Trini	ty I	per place) Temor	cial	Gard				ldorf				
	Mark M B	rohan	in		F	. 0	. Box	156	l Home 6, Wal	dorf	, Md.	206	504-0	156	
	23. PART J. Enter tha diseases, or shock, or heart fellure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Card	se on each line.			the mo	da of dyl	ng, suci	h as cardia	c or respi	ratory arr	est,	Inte	roximsta rval Betw et and D	veen leath
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	b. Arterio	(OR AS A CONSEO	HIZ DENCE O	OCC	clu.	silve	des	casc					( ) >	
MEDICAL	PART II. Other significant condition	a contributing to	death but not ra	sulting	in the un	dariying	g cause g	ivan in i		Ia. WAS AN PERFOR	IMED?	24b	. WERE AUT AVAILABLE COMPLETE OF DEATH	PRIOR TO ON OF CAUS	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 NO	HOSPITAL:	ER/Outpatient 3 (	DOA	OTHER	R:			eck only one)	ipecify)					
ВУ РН	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF (Month, D	ny, Year)		E OF URY M	28c. INJI WO 1   Y	URY AT RK? 'ES 2		28d. DESCR		NJURY OCC	URED			
ETED.	3 Suicide 8 Could not be determined	bullang,	F INJURY — At homeone. (Specify)							lown, State)			loute Numbe	N,	
COMPLET	2 MEDICAL EXAMINE	CIAN: To the best of R: On the beels of e											and mann	er an state	ıd.
TO BE	296. SIGNATURE AND TITLE OF CERTIFIER  JOYNA LINEAL  30. NAME AND ADDRESS OF PERSON WH	rile, MI					29c. LICE D- 4	36			29d, DATE ▶ 3	SIGNED / 200	(Month, De	( Year)	
- 1	THE PROPERTY OF PERSON WH	O DOMPLETED CAUS	TOT DEALH (ITEM	41) (Type,	rnnt)										

Pembrooke Square #104, Waldorf, Md.

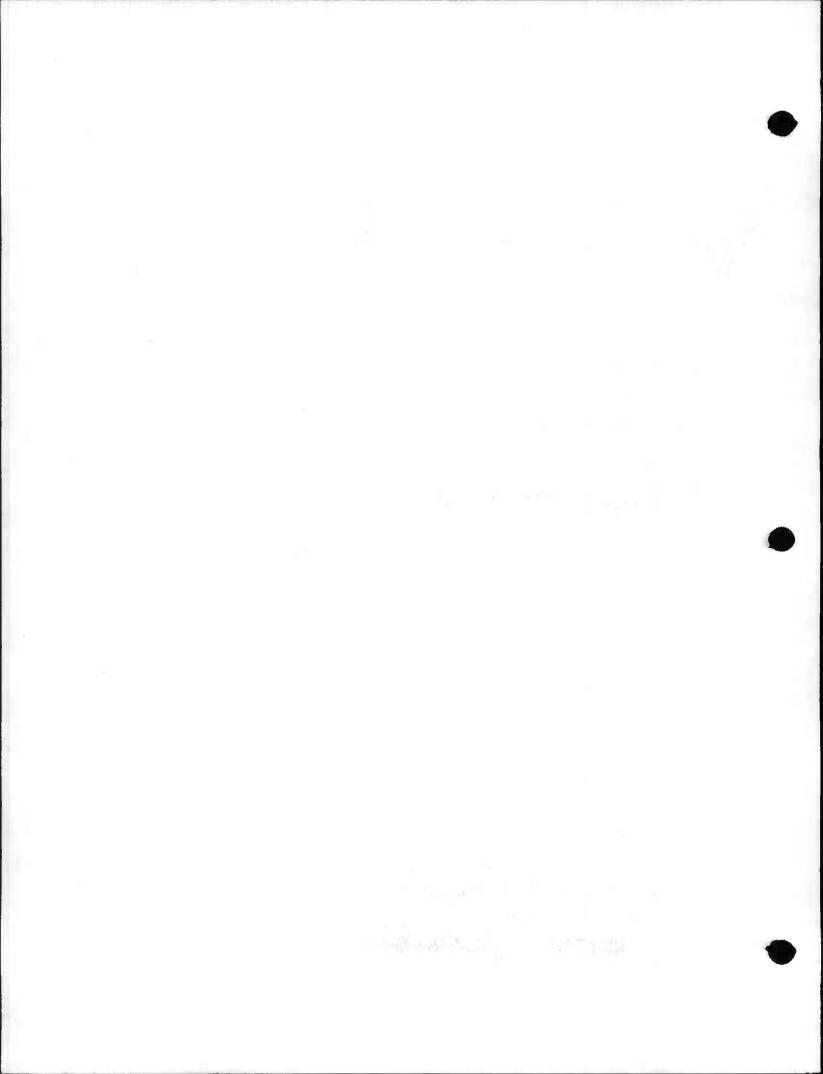
32. REGISTRAR'S SIGNATURE

Julia Davidson Andreas



-	FOR STATE REGISTRAR	STATE OF	MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.	93
1. 0	DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH MONTH DAY	YE
	Fritz	(IMMI)	Reinke	March 14	1993

1. DECEDENT'S NAME (First, Middle, Last)  Fritz	(NMI) Re	inke				2. DATE MONTH		1993	AR	:00 a
4. SOCIAL SECURITY NUMBER		AGE (In yrs. last birt		R 1 YEAR	IF UNDER 24 HRS.	7 DATE	OF BIRTH	0.0	IRTHPLACE (S	State or Foreign
217-58-7907	1 M 2 F	70 v	/RS. MONTHS	DAY8	HOURS MIN.		7 27,192		ussia	
9a. FACILITY NAME (If not institution, give s Residence: 648 Ri					OR LOCATION OF DE	EATH		c. COUNTY C		
RESIDENCE OF DECEDENT	dge Road		R1	sing	Sun			Ce	cil	
10a. STATE 10b. COUNT		10	c. CITY, TOWN						LIN	SIDE CITY
Maryland	Cecil		Risi							s 2XXNO
100. STREET AND NUMBER 648 Ridge Road				101	I. ZIP CODE	911	1		S.A.	UNTRY?
11. MARITAL STATUS	12. WAS DECEDENT E	VER IN U.S. ARMED	13.	WAS DEC	ENDENT OF HISPAI		? (Specify Yas or	No.— 14. F	RACE - Amer	ican Indian,
1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 IF YES, GIVE WAR	YES 2 NO OR DATES		If yes, sp 1 TYES	ecify Cuban, Maxica 2 NO Specifi		tican, atc.)		Black, White, Specify:	
15. DECEDENT'S EDU	CATION	16a DECED	ENT'S USUAL (	CCI IDATI	ON	185	KIND OF BUSIN	EGG/INDHIGTS		<u>ite</u>
(Specify only highest grade Elementary/Secondary (0-12)		(Give k	ind of work done NOT use retired.	during mo			arford '			e, Inc.
Eight Years		La	aborer			W	nitefor	d, Mar	cyland	
17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA			mame)		
Arthur Re	inke					a Mi				
19a. INFORMANT'S NAME (Type/Print) Olga Lucie Elsa R	einke				and Number or Rural					
20a. METNOD OF DISPOSITION	CTHE		-	_	metery, cremetory or	g sui			or Town, State	
1 Donation 5 Other (Specify)	noval from State	R.A. Fe	erris &	Con	many or				er, Pe	
21. SIGNATURE OF FUNERAL SERVICE D	CENSEE	111111111111111111111111111111111111111	22	. NAME A	ND ADDRESS OF FA	CILITY				
Dan 1	Russia	1.60		Lee	A. Patt	erso			cal Ho	me
23. PART i. Enter the diseases, or	compileations that of	eused the death	. Do not ente		ryville,				1.4	pproximete
shock, or heart feliure.	List only one ceuse	on aech ilne.				^		,	- In	tervai Betwee
iMMEDIATE CAUSE (Final disesse or condition	(1/21/2)	Bral 1	[ MAG.	00.1	ascic	PRAT			1,	h o
reaulting in death)	DUE TO (O	R AS A CONSEQUE	NCE OF):	_	use C					IVEO
	three	Tensi	re A	Se	11)					2 Yrs
Sequentielly list conditions, if any, leading to immediate	60 10 to	R AS A CONSEQUE	NCE OF):							t
CAUSE (Diseese or injury	c	R AS A CONSEQUE	NCE OF:							
that initiated events resulting in death) LAST									į	
DART II Onbes discullance on the	v	- Ab bus - A	141 1 -4		Company and the					
PART ii. Other significent condition	ine contributing to de	vain but not reeu	iring in the c	ıngeriyin	g ceuse given in	Part i.	24a. WAS AN AU PERFORMI	ED?	AWAILAE	UTOPSY FINDINGS ILE PRIOR TO ETION DF CAUSE
					<del></del>	—	1 TYES 2	NO	OF DEA	TH?
									1 🗌 Y	ES 2 NO
25. WAS CASE REFERRED TO MEDICAL				28. P	LACE OF DEATN (C/	heck only or	ne)			
EXAMINER?	HOSPITAL:	R/Outpatient 3 🗍	DOA 4 N	R:	ne 5 X Residence					
27. MANNER OF DEATN	26a. DATE OF IN	JURY 20	b. TIME OF	28c. IN.	JURY AT	_	SCRIBE HOW INJ	URY OCCURE	ED	
1 Natural 5 Pending 2 Accident Investigation	(Month, Day,	rour)	INJURY		ORK? YES 2 NO					
3 Suicide 6 Could not be	28e. PLACE OF I building, et	NJURY — At home, c. (Specify)	farm, street, fa	ctory, offic	D0		ATION (Street end or Town, State)	Number or R	tural Route Nur	mber,
4 Homicide determined						J,	,			
	SICIAN: To the best of m	y knowledge, daeth	occurred at the	time, data	and place, and du	a to the car	use(a) and menne	or as stated.		
one) 2 MEDICAL EXAMIN	ER: On the basis of exam	mination and/or inve	stigation, in my	opinion,	death occured at the	time, data	and placa, end	dua to the ca	use(a) and m	nner as stated.
296. SIGNATURE AND TITLE OF GERTIFIE	R IVI T	0 E			29c. LICENSE NU	MBER	0- 1	Ped. DATE SIG	GNED (Month,	Day, Year)
Judles	Hull	D-1/2	>		100	44	821	> 5	1151	93
30. NAME AND ADDRESS OF PERSON & Dudley Phillips	, M.D., Da	rlington	, Mary	land	21034					
31. DATE FILED (Month, Day, Year)				_						
MAR 17 '9	3 gret	s signature ia Davidson	-Mandall							
	- ()					_				



Sequentistiv list conditions.

if any, lasding to immediata cause. Entar UNDERLYING

CAUSE (Disease or Injury

29b. SIGNATURE AND TITLE OF CERTIFIER

MAR 23

31. DATE FILED (Month, Day, Year)

1 an cus

1

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type. Print)

TIMOTHY P. CODD, M.D./1202 HILLIAM STIDERS

that initiated events resulting in death) LAST

iges 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending page.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burn	be filed within 72 hours after death with the State Deptr. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
	2	2	8	X

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COMPLETED

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

93 09503 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH DAY JOHN SLAVIN 03 20 93 10:36 PM M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign 212-03-815 1 M 2 - F MI 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH FUNERAL DIRECTOR ARUNDEL NORTH HOSPITAL ASSOCIATION GLEN BURNIE COUNTY RESIDENCE OF DEC 10a. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MI HRUNDE IERNA 1 YES 2 NO 10e, STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 05 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 RO Specify: FORCES? FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 2 Marrie 2 NO 1 Never Married BY 3 🗌 Widowed 4 🔲 Divorced COMPLETED 16e. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION (Specify only highest grade complete (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) OWNER 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, BE AVIN INFORMANT'S HAME (Type/Print) 19b. MAILING ADDRESS (Street 5 20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 20b. PLACE AND DATE OF DISPOSITION (Name of DAVE 3 | Removal from State 22. NAME AND ADDRESS OF FACILITY DARRANCOF 24146 MA 23. PART L. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory **Approximate** shock, or haart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Finsi Onset and Death Cardiac Arrest resulting in death) DUE TO (OR AS A CONSEQUENCE OF): aortic stenosis PHYSICIAN: MEDICAL CERTIFICATION

PART II. Other significant condition	na contributing to death but not	reaulting in	tha u	nderlying cause given in	Part I.	24a. WAS AN AUTOPSY PERFORMED 1 YES 2 NO	24b. WERE AUTOPSY FINDIN AMALABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHE	26. PLACE OF DEATH (C	neck only o	ne)	
1 VES 2 NO	1 Inpatient 2 ER/Outpatient	3 DOA	4 🗌 Nur	rsing Home 5 🗌 Rasidence	8 🗌 Oth	er (Specify)	
27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME		28c. INJURY AT WORK? 1 YES 2 NO	28d. DE	SCRIBE HOW INJURY OCCU	RED
3 Suicide 8 Could not be determined	28a. PLACE OF INJURY — At h building, etc. (Specify)	nome, farm, str	reet, fac	tory, offica	28f. LO	CATION (Street and Number of or Town, State)	Rural Routa Number,
29a. CERTIFIER (Check only	ICIAN: To the best of my knowledge, d	leath occurred	at the t	time, data and place, and du	to the ca	use(a) and manner as stated	ı.

W)

Bridge

2 [ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

29c. LICENSE NUMBER

SeverNA PARK

DO 1103

ALTIMORE, MARYLAND

DUE TO (OR AS A CONSEQUENCE OF):

hyperlipidemia
DUE TO (OR AS A CONSEQUENCE OF):

arteriosclerosis

ods

32 REGISTRAR'S SIGNATURE Julia Davidson-R

DHMH-16 Rev 1/89

29d. DATE SIGNED (Month, Day, Year)

3 - 23-93

use as the 9 must age of

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physicial	FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-la	within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.	ITANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
quires that the death	n signed by the after	Health and Mental	ows any injury, o
SICIAN: The law re	certificate has bee	the State Dept. o	, or item 23 sh
ATTENDING PHYS	CTOR: After this (	after death with	28 is marked
HOSPITAL OR A	FUNERAL DIREC	within 72 hours	TANT: If Item

TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: 9

31, DATE FILED (Month, Day, Year)

MAR 23

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93 09504 ITEMS: 23 PART I, 27,28a,b,d,e,f, PER MEO G-698 4/8/93 FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MELINDA SPATES 0.3 1993 8:33 A SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH B. BIRTHPLACE (State or Foreign Country) 216-38-6599 DAYS HOURS 1 - M 2/XF 27 09 Florida 04 1965 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF CEATH DIRECTOR ARUNDEL GENERAL HOSPITAL ANNE ANNAPOLIS ANNE ARUNDEL 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Anne Arundel Annapolis XX YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WNAT COUNTRY? 711 Tyler Avenue 21403 United States 11. MARITAL STATUS 13. WAS DECENCENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yea. specify Cuben. Mexican, Puerto Rican, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 NO 14. RACE — American Indian, 1 Never Married 2 Merrie 3 Widowed 4 Divorceri If yes, specify Cuben, Mexican, Pu 1 YES 2 XNO Specify: IF YES, GIVE WAR OR DATES BY White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest Save the Bay Elementary/Secondary (0-12) College (1-4 or 5+) Volunteer Staffing Providence Center & 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname, Judith Thomas Michael Spates BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Judith Gleixner 711 Tyler Avenue Annapolis, Maryland 21403 20e. METHOD OF DISPOSITION

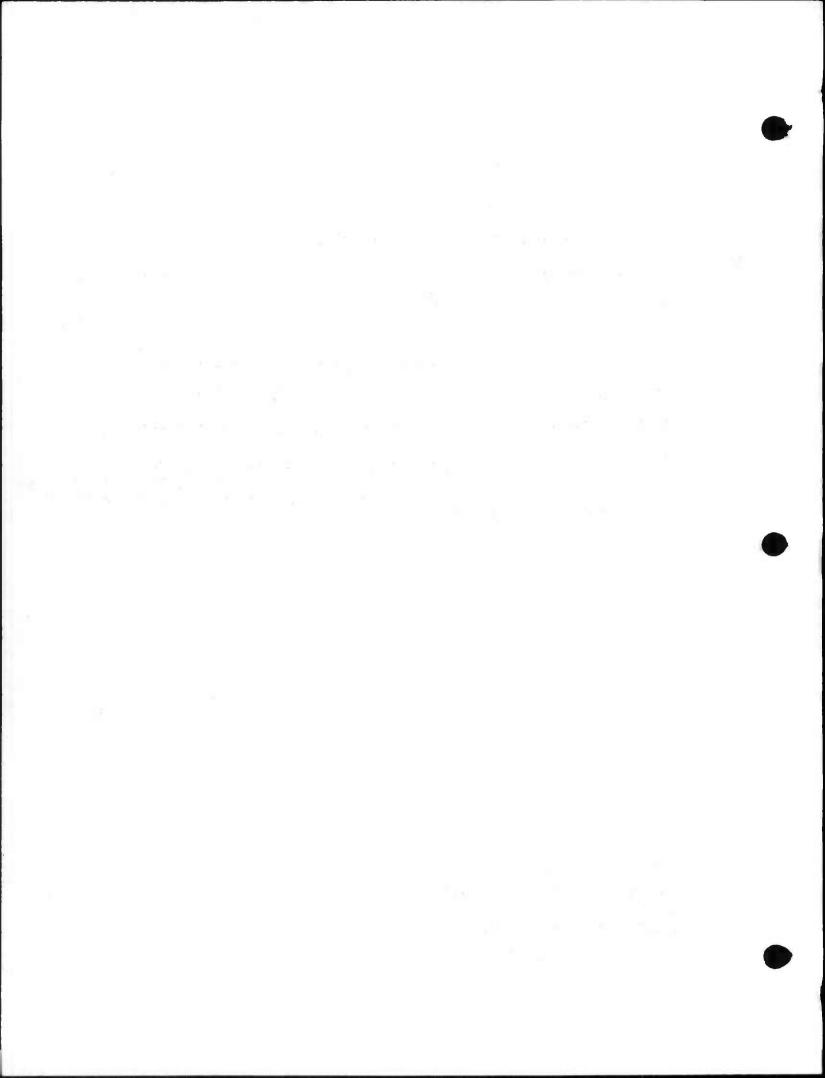
1 M Sourial 2 Cremation 3 Removal from State
4 Donation 5 Dither (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Olivet Cemetery St. Michaels. Maryland 03 - 20 + 9322. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 147 Duke of Gloucester St. Annapolis, MD 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdisc or respiratory arrest, abock, or heart failure. List only one cause on each line. Approximate IMMEDIATE CAUSE (Final Onset and Death disease or condition PROPOXYPHENE INTOXICATION resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE YES 2 NO OF DEATH? YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 TYES 2 NO nt 2XXXR/Outpatient 3 DOA me 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26% TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 7:00 AM BY Found: 3-14-93 1 YES 2 NO UNKNOWN 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 4 Homicide 711 Tyler Avenue 29e. CERTIFIER
(Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. 2 X MEDICAL EXAMINER: On the beals of axamination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. TURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE O.C.M.E. 03/15/1993 9

OF OEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

Penn Street, Baltimore, Maryland

DHMH-16 Rev 1/89



YEAR

3. TIME OF DEATH

2. DATE OF DEATH MONTH 18,

DAY

1993

Elizabeth

Storton

- 4	4. SOCIAL SECURITY NU		5. SEX	8. AGE (In yrs		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATI	e of Birth	8	BIRTHPLACE (Sta Country)	-
ļ	820-02-720			86	Rd.	9b. CITY, TOWN	OR LOCATION OF	-	06 19		Maryland	1
10 E	Country Ho	me Care		lomons			wood				e Arund	el
DIRECTOR	10e. STATE MD	10b. COUNTY	Arundel			, TOWN OR LOC Davids C					10d. INSID	E CITY
	10e. STREET AND NUMBE	ER				1	Of. ZIP CODE				N OF WHAT COUN	TRY?
FUNERAL	652 Rang	ger Cour					21035	5		Unit	ted State	28
à	11. MARITAL STATUS 1 Never Married 2 [ 3 XXWidowed 4 D		12. WAS DECEDEN FORCES? 1 IF YES, OIVE V	TEVER IN U.S. YES 2X WAR OR OATES	ARMED	If yes, s	CENDENT OF HISP specify Cuban, Maxi S 2 NO Specific	can, Puerto	IN? (Specify Yes Rican, etc.)	or No-	4. RACE — America Black, White, etc Specify: Wh	in Indian, i.te
COMPLEIED		PECEDENT'S EDUC only highest grade y (0-12)			(Give kind of w life. Do NOT use	17 - 11		16	b. KIND OF BUS		STRY	
	9 17. FATHER'S NAME (First,	Address ( a and )			Hom	emaker			Hor			
- 11	George S		ield						Middle, Maiden Constar			
4	19a. INFORMANT'S NAME				19b. MAILINO	ADDRESS (Street	and Number or Rurs				ode)	
2	Theresa	Cadell			652 R	langer (	Court Do	ivids	onville	e, Mar	yland 2	1035
	20a. METHOD OF DISPOS	BITION atlon 3 - Reme	oval from State	20b. PLA	CE AND DATE O	F DISPOSITION (I	Vame of	DA	TE 20c. LO	CATION — CH	ty or Town, State	
	4 Donation 8 DOth	her (Specify)	-a	Mill	crest	Cemeter	LU AND ADDRESS OF I		Anna	apolis	, Maryl	and
	for a forest	1	YI	//		22. NAME /	AND ADDRESS OF I	ACILITY J	ohn M.	Taylo	r Funer	al Hom
4	Male	VX.	Juj/			1	Puke of (				•	, MU
	IMMEDIATE CAUSE (I	naert fallure, i	List only one car	t caused the ise on each i	death. Do n line.	ot entar tha m	ode of dying, au	ch ea ca	rdiac or reapi	ratory arrea		roximata rvai Batwee
	disease or condition		L			4						et and Deal
	disease or condition resulting in death)		a. Jus m	reces	von (	2						
_			DUE TO	(OR AS A CON	SECULENCE OF	١٠	28 F	ail	2			et and Deal
NOI	resulting in death) Sequentially list cond	ditions,	DUE TO	(OR AS A CON	SECULENCE OF	١٠	art f	ail	- L-			et and Daar
ICATION	resulting in death)	ditions, nediete LYING	DUE TO	OR AS A CON OR AS A CON SCUT	SEQUENCE OF	): e /ks	no f	ail	2			et and Deat
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1 -	STATE REGISTRAR

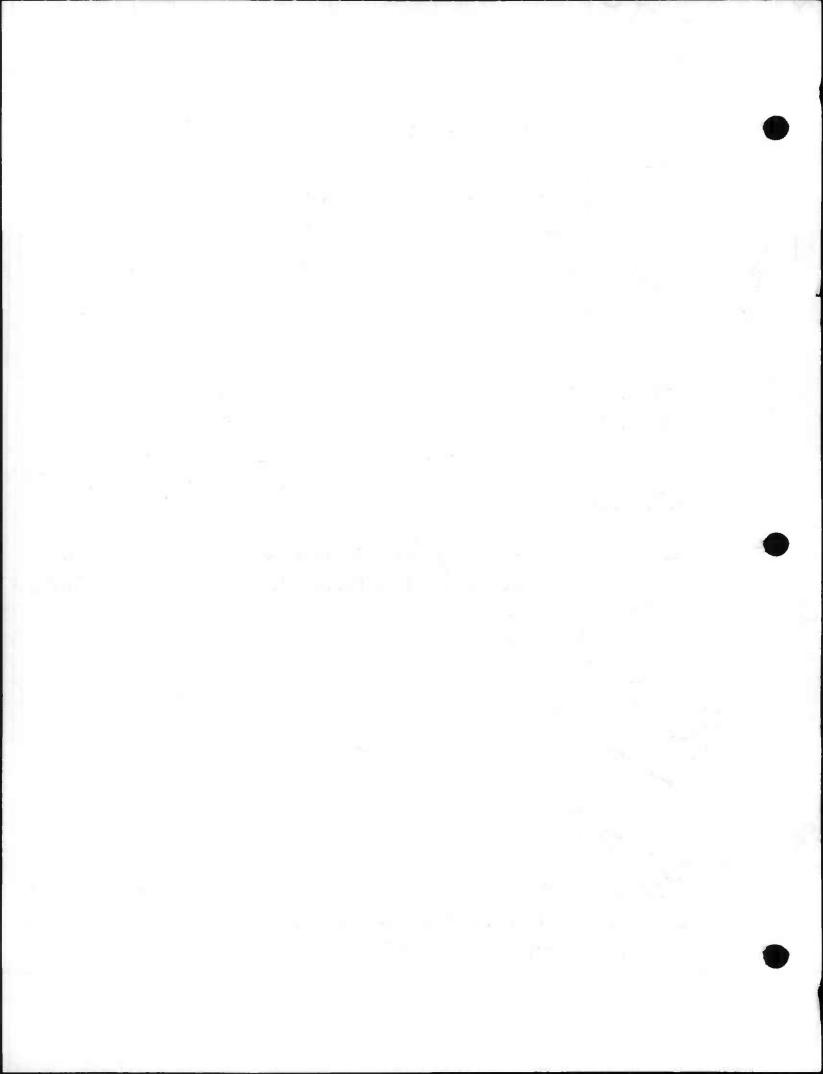
## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	CERTIFIC	CATE OF DEATH	REG. NO.	
	1. DECEDENT'S HAME (First, Middle, Last)			2. DATE OF DEATH	3. TIME OF DEATH
	Anna Elizabeth	Suitt		March 20. 19	93 YEAR 2300 M
	4. SOCIAL SECURITY NUMBER 5. SEX 6.	AGE (In yrs. last birthday)	F UNDER 1 YEAR F UNDER 24 HRS.	7 DATE OF BIRTH	8. BIRTHPLACE (State or Foreign
	216-32-5057 ¹□™ XXX	87 YRS.	ONTHS DAYS HOURS MIN.	Feb. 01, 190	16 Maryland
FOR	9e. FACILITY HAME (If not institution, give street and number)  Anne Arundel Medical CEnteressiblence of Decedent		Annapolis		county of DEATH INE Arundel
E	10a. STATE 10b. COUNTY		TOWN OR LOCATION		Tand mining outs
DIRECTOR	Maryland Anne Arundel		Annapolis		10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	100. STREET AND HUMBER 228 Summer Road		21401	715	CITIZEN OF WHAT COUNTRY? United States
BY FUN	11. MARITAL STATUS  1 Never Married 2 Married   FORCES? 1   IF YES, GIVE WAR	YES XXHO	13. WAS DECENDENT OF HISPAN If yes, specify, Cuben, Mexicae 1 YES 2 NO Specify	IC ORIGIN? (Specify Yes or No., Puerto Rican, etc.)	Black, White, etc. Specify:
	15. DECEDENT'S EDUCATION	18a. DECEDENT'S US	BILL OCCUPATION	16b. KINO OF BUSINES	White
	(Specify only highest grade completed)	(Give kind of wor	k done during most of working	100. KINO OF BUSINES	SINDUSTRY
COMPLETED	8	Home	maker	Home	
00	17. FATHER'S HAME (First, Middle, Lest)  JOHN P. COLLINS			ME (First, Middle, Meiden Surne ) Sa A. Mayheu	· ·
BE	19a. IHFORMANT'S HAME (Type/Print)	19b. MAILING AL	DDRESS (Street and Number or Rural F		
2	Rose V. Karangelen	228 Su	mner Road Anno	ipolis, Maryl	and 21401
	20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF I	DISPOSITION (Name of Care) Care Care Care Care Care Care Care Care	DATE 20c. LOCATIO	N — City or Town, State
	1. SIGNATURE OF FUHERAL SERVICE LICENSEE	meachesi C	22. NAME AND ADDRESS OF FAC	SUTY Tohn M To	ylor Funeral Home
	Donald S. Tust		147 Duke of Gl	Loucester St.	Annapolis, MD
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	on each line.	enter the mode of dying, such		y arrest, Approximate Interval Between Onset and Death  5 years Wany
	resulting in death) LAST				
	PART II. Other significant conditions contributing to de	ath but not requiting in	the underlying saves along to	Dark I. Law und au wen	
MEDICAL			the underlying cause given in	Part I. 24a. WAS AN AUTO PERFORMED?  1   YES 2   N	AMILABLE PRIOR TO
ä					
Sic.	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 NO 1 Inpatient 2 E		26. PLACE OF DEATH (Chi		
PHYSICIAN:	27. MAHHER OF DEATH 28s. DATE OF IN. (Month. Day)	IURY 28b, TIME C		8 Other (Specify)  28d. DE\$CRIBE HOW INJURY	/ OCCURED
B	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be 28e. PLACE OF IN	JURY — At home, farm, stre	M 1 YES 2 NO	281. LOCATION (Street and No.	imber or Rural Route Number
ETED	8 Could not be determined building, etc.	(Specify)		City or Town, State)	The state of the s
COMPLETED	29e. CERTIFIER (Check only one)  2 MEDICAL EXAMINER: On the basis of exam				
TO BE	296. SIGNATURE AND TITLE OF CERTIFIER / KMZO	MD	DO5	928 Þ	March 22, 1993
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF LAND AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF LAND AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF LAND AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF LAND AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF LAND ADDRESS OF LAND A	MD. 18	3334 Forest ]	r., Annapo	lis, MD 21401
	31. DATE FILED (Month, Dev. 16er)  MAR 2 3 1998 Fiche D	widson-Rindall		/	

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trail be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. **BALTIMORE, MARYLAND 21215-0020** DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 Rev 1/89



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BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Por PL 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

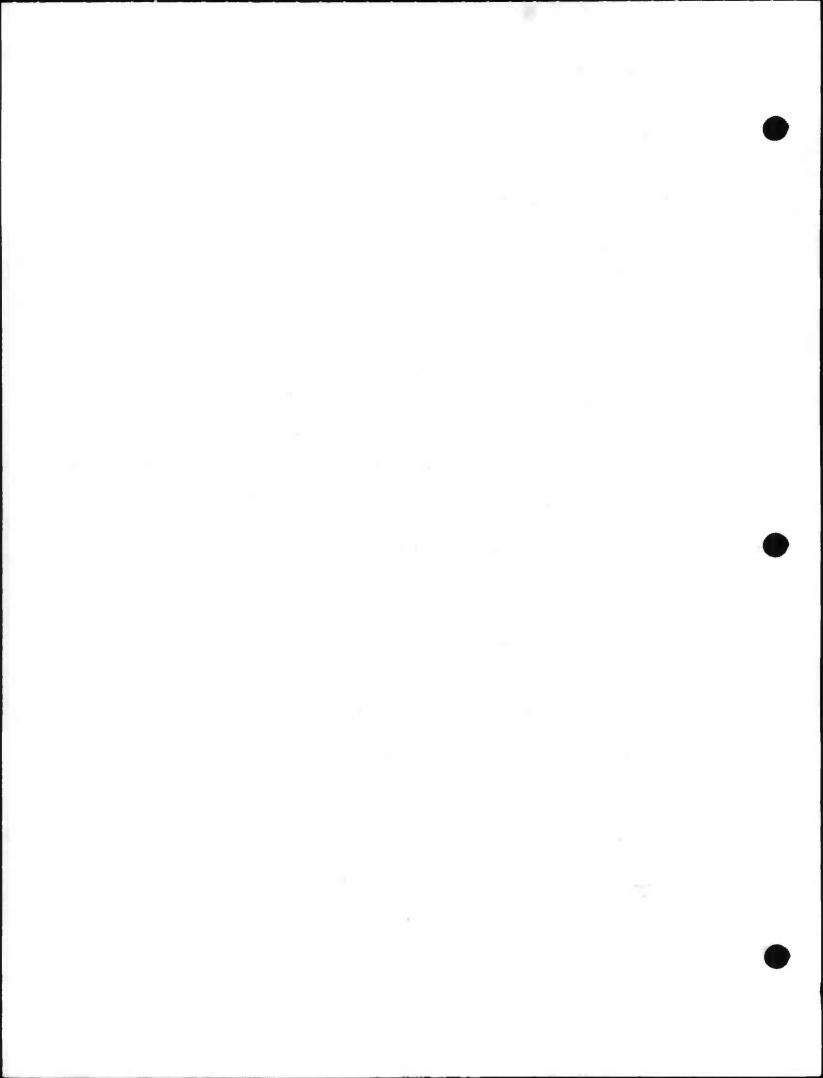
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 3	1. DECEDENT'S NAME (First, Middle, Lest)  2. DATE OF DEATH MONTH MONTH 19 1993  3. TIME OF DEATH MONTH MONTH 19 1993  09030M																
. 1	Cora												March 19,1993 0903A				
	4. SOCIAL SECURITY NUMBER 213-24-956		5. SEX 1  M 2  F	6. AGE (In yrs. lest	birthday) YRS.	IF UNDER	1 YEAR DAYS	HOURS	R 24 HRS. MIN.	7. DATE	OF BIRTH h, Day, Year) y 21,1	900	a. BIRTI Count	IPLACE (State or Foreign y) MD			
TOR	9a. FACILITY NAME (If not in CATTOL	e Coun	ty Hosp.			96. CITY, TOWN OR LOCATION OF DEATH  Westminster  Carroll						EATH					
DIRECTOR	10a. STATE		10c. CIT	y, town o	ches	ter						10d. INSIDE CITY LIMITS? 1 1 YES 2 NO					
FUNERAL	3332 Mach			101. ZIP CODE 21102							10g. CITIZEN OF WHAT COUNTRY?						
BY	11. MARITAL STATUS 1 Never Married 2  3 /Widowed 4 Dive	IT EVER IN U.S. ARN YES 2 7 NO MAR OR DATES	MED	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.)  1 U YES 2 NO Specify:  White						k, White, stc.							
COMPLETED	15, DEC (Specify oni Elementary/Secondary (t	EDENT'S EDU- ly highest grade 0-12)	CATION completed) College (1-4 or 5	+) (Giv	e kind of v Do NOT us	USUAL OF WORK done of retired.)	during mo	ON ist of work	ing	164	KIND OF BU	SINESS/IN					
S	17. FATHER'S NAME (First, A							18. MOT	HER'S NA	ME (First,	t, Middle, Meiden Surneme)						
BE (	John Stones											nesifer					
70	190. INFORMANT'S NAME (Type/Print)  190. MAILING ADDRESS (Street and Number or Rural Ploute Number, City or Town, State, Zip Code)  Janet Selby  4601 Grand Valley Rd. Westminster. MD21158																
	20a. METHOD OF DISPOSITION  1 General Particle 2 Greenation 3 General From State  4 Donation 5 Gother (Specify)  20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery 3 General Particle).  20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery 3 General Particle).  20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery 3 General Particle).  20c. LOCATION — City or Town, State Cemetery 3 General Particle Partic																
	21. SIGNATURE OF PONERO	SENTICE LIC	enegle Le	ula	, (	) 22.	NAME AI	es F	H. 3	ситу 4 Ма	ple Av	e.li	ttle	17340 stown, PA			
	23. PART I. Enter the dahock, or h IMMEDIATE CAUSE (Fit disease or condition resulting in death)	aart fallure. nai	List only one car	use on each line.						h as car	diac or reap	iratory a	rrest,	Approximata interval Between Onset and Desth			
CERTIFICATION	disease or condition resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):  OUE TO (OR AS A CONSEQUENCE OF):  OUE TO (OR AS A CONSEQUENCE OF):																
SE	d.																
MEDICAL	PART II. Other signification of the control of the	sulting	in the un						AUTOPSY RMED? 2 1 NO	246	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO						
ä		0															
PHYSICIAN:	25. WAS CASE REFERRED TEXAMINER?  1 YES 2 AND	O MEOICAL	HOSPITAL:	☐ ER/Outpatient - 3 [	□ DOA	OTHER	₹:		DEATH (Ch		ne) er (Specify)						
		Pending Investigation	28e. OATE Of (Month, I	INJURY	28b. T/M		28c. IN.				SCRIBE HOW	INJURY O	CCURED				
TED BY	2 Accident 3 Suicide 8 Homicide	Could not be determined	28e. PLACE ( building	OF INJURY — At hom, etc. (Specify)	ne, ferm, i	street, fact	ory, offic	•		28f. LOI City	ATION (Street or Town, State	and Numbe	or or Rural	Route Number,			
COMPLETED	onel			i my knowledge, dea examination end/or in										e) end manner se stated.			
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER  Devel & Leberthe								ENSE NUI			•	19	(Morth, Day, Your) Can 193			
-	DOWA L	F PERSON WH	D. CO	SE OF DEATH (ITEM	27) (Type	Print)	42	h	113 ASF	1/11	WEST GT	Im	IN:	STER,			
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	SPITAL DRIVENING PHYSICIAN: The law requires that the death certificate be executed within 24 hours at
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		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	NAV VE	3. TIME OF DE	EATH		
•		Edward John Se	mok				3 2.	199	3 8:22	p A		
9		4. SOCIAL SECURITY NUMBER 174-14-0374	1 M 2 □ F 7	(In yrs. lest birth	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 9-15-1918		BIRTHPLACE (State or Country) ennsylvar	- 100		
should	-	9a. FACILITY NAME (If not institution, give			9b. CITY, TOWN	OR LOCATION OF D	PEATH	9c. COUNTY	OF DEATH			
3	DIRECTOR	3321 Oak Stree	et		Manch	ester		Car	roll			
1	E C	10e. STATE 10b. COUNT	ΤΥ	10c.	CITY, TOWN OR LOCA	TION			10d. INSIDE CI	ITY		
	ä	Maryland C	arroll		Manche	ster		LIMITS?				
- 1	1A	10e. STREET AND NUMBER			10	r. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?				
an. Transit	FUNERAL	3321 Oak Str				21102			U.S.A.			
hours after death. Page 6 may be retained by the hospital or attending physician.  The funeral director, page 5 should be detached for use as the burial-transit, or removal.  The funeral medical examiner must be notified at once.	TO BE COMPLETED BY	11. MARITAL STATUS  1 Never Married 2 Married  3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 A YES IF YES, GIVE WAR OR 1 1943-1946	IN U.S. ARMED  2 NO DATES	If yes, sp		NIC ORIGIN? (Specify Ye an, Puerto Rican, etc.) fly:	s or No 14.	RACE American in Black, White, etc. Specify: Whit			
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by the hor be detach at once.		17. FATHER'S NAME (First, Middle, Last)					AME (First, Middle, Meiden	Surname)	urneme)			
5 should to		John Szemak  19a. INFORMANT'S NAME (Type/Print)		10h MAI	ING ADDRESS /Street		Route Number, City or Tox	on Chata Tip Co.	4-1			
5 should notified		Theresa M. Semok					chester, MI					
page tt pe		20s, METHOD OF DISPOSITION	20	b. PLACE AND D	TE OF DISPOSITION /N	ame of	DATE 20c LC	CATION - CITY	or Town State			
rector, p		1 Densition 5 Other (Specify)	noval from State	eadowri	dge Mem.	Park 3-2	4-1993 Bal	Ltimore	, MD.			
death. Pag tuneral dii I. examiner		21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE		22. NAME A	ND ADDRESS OF F	ral Chapel					
after death. Page 6 m by the funeral director, emoval.		I South	reshold				Drive, Mar		r. MD. 21	102		
d in by the or removal		23. PART i. Enter the diseases, or abook, or heart fellure.	complications that ceuse List only one ceuse on	d the desth.	Do not enter the mo	ode of dying, suc	ch as cerdlec or resp	iratory arrest,	Approxi	imete		
24 hou filled i	1 1	IMMEDIATE CAUSE (Fins!	and only one odder on	~~\i	0					Between and Death		
within 24 pletely fill cremation, rent, the		disease or condition resulting in desth)	a	210	mach	Com	Cer		24	cors		
P	_	_	DUE TO (OR AS	A CONSEQUENC	E OF):							
and to bu	RTIFICATION	Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING										
the death certificate be in the attending physician d Mental Hygiene prior to injury, or other traun	TIFIC	CAUSE (Disesse or injury that initieted events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):									
attend attend mtal Hy	CER	Continue in detail, cross	d									
	EDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.  24a. WAS AN AUTOPSY PERFORMED?  1   YES -8   100										
w requires that been signed I pt. of Health a 3 shows any	WE								OF 0EATH?	NO		
has bee Dept. c	AN											
PHYSICIAN: The la this certificate has with the State Der rked, or item 23	SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 MO	HOSPITAL:	patient 3 🗆 DC	OTHER:	LACE OF DEATH (C	6 Other (Specify)					
NSICIA is certif ith the	РНҮ	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b.	TIME OF 28c, IN.	JURY AT	28d. DESCRIBE HOW	INJURY OCCUR	ED			
DING PHYS After this death with	ВУ	2 Accident Investigation			M 1 🗆	YES 2 NO						
DR ATTENDING DIRECTOR: After hours after death item 28 is ma	ETED	3 Suicide 6 Could not be 4 Homicide determined	26s, PLACE OF INJUR building, etc. (Spe	Y — At home, fe	rm, atreet, factory, offic	ce ·	261. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
五年 五日	COMPLE		SICIAN: To the best of my know ER: On the basis of examination						use(a) and manner ar	stated.		
THE HOSPI THE FUNEF filed within	ш	296. SIGNATURE AND THE OF CENTIFIE	ER			29c LICENSE NU	MBER	29d. DATE SIG	GNED (Morgh, Day, Yee	ar)		
TO THE De filed IMPOR	0 B	IN	W)			M331	65		lanch ZZ			
	_	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF DE	11 61-	Type, Print) Unescr P	ika No	emported	my	45015			
Y		MAR FILED Moon 39, Year)	32. REGISTRAR'S SIGN	NATURE Condess								

	REGISTRAR C	ERTIF	CATE O	F DEATH	REG. NO							
	1. DECEDENT'S NAME (First, Middle, Lest) Elizabeth Alice Swartz				2. DATE OF DEATH	14. 199	YEAR 3. TIME OF DEATH					
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. to	est birthday)	IF UNDER 1 YEA	R IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (State or Foreign					
	577-26-7010 1 M 2 XF 90	YRS.	MONTHS DAY	8 HOURS MIN.	03/10/190	3	Frederick, MD					
OB B	Pleasant Living Nursing Home			n or Location of D water	EATH		Y OF DEATH Arundel					
딥	RESIDENCE OF DECEDENT  10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY											
DIRECTOR	Maryland Anne Arundel		napolis	11000			LIMITS?					
Z	10e. STREET AND NUMBER			10f. ZIP CODE		10g. CITIZE	N OF WHAT COUNTRY?					
剪	285 Cape Saint John Road			21401		U.	.S.A.					
BY FUNERAL	11. MARITAL STATUS  1 Never Married 2 Married  2 Married 3 Widowed 4 Olvorced  12. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 WIF YES, GIVE WAR OR DATES	RMED NO	If yes,	DECENDENT OF HISPA apocity Cuben, Mexico (ES 2 NO Specific		or No- 14	4. RACE — American Indian, Black, White, etc. Specify: White					
	15. DECEDENT'S EDUCATION 16a. D	ECEDENT'S	USUAL OCCUP	ATION	16b. KIND OF BU	SINESS/INDIA						
	(Specify only highest grade completed) ((	Give kind of w le. Do NOT us	ork done during	most of working	TOOL KIND OF BO	JINE 33/11003	aini					
릴		House	wife		Own	Home						
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)			18. MOTHER'S NA	ME (First, Middle, Meiden							
BE (	Raymond E. Eyler			Katie I	M. Lamber	t						
10					Route Number, City or Tow							
-						•	, MD 21401					
	20b. PLACE AND DATE   D											
1	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22 NAME	AND ADDRESS OF EA	CILITY							
	· Sack & Free I		Fran	ncis Gasci	n's Sons F	uneral	l Home, P.A. tsville, MD					
$\neg$	23. PART I. Enter the diseases, or complications that caused the d	eath. Do n	ot enter the	mode of dving. suc	h sa cardiac or reani	retory erres	tt, Approximate					
	immediate CAUSE (Final	6.				rutory orros	Interval Between					
	IMMEDIATE CAUSE (Final disease or condition resulting in death)											
ï	DUE TO (OR AS A CONSEQUENCE OF):											
Z	disease or condition resulting in death)  a. Cavabra Throm Gosis  Due to (or as a consequence of):  Sequentially list conditions,  b. Generalized atherosclerosis  Chronice											
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING											
은	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSE	OUENCE OF	):									
듄	resulting in death) LAST		,				j					
	0											
CAL	PART II. Other significant conditions contributing to deeth but not	rasulting in	n the underly	ring cause given in	Pert i. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO					
ᅙᅢ	Organic dementia				1 _ YES 2	No	COMPLETION OF CAUSE DF DEATH?					
ž	- Anomia NOS						1 _ YES 2 _ NO					
ÿ												
PHYSICIAN: ME	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:		OTHER:	PLACE OF DEATH (Ch	eck only one)							
ı X	1 YES 2 NO 1 Inpetient 2 ER/Outpatient	1	4 Nursing H	iome 5 🗆 Residence	8 Other (Specify)							
	27. MANNER OF DEATH  28e. DATE OF INJURY (Month, Day, Year)	28b. TIME	JRY	INJURY AT WORK?	28d. DESCRIBE HOW I	NJURY OCCUP	RED					
à	2   accident investigation			YES 2 NO								
COMPLETED	3 Suicide 4 Homicide  8 Could not be determined  28e. PLACE OF INJURY — At he building, atc. (Specify)	ome, farm, s	treet, factory, or	ffice	281. LOCATION (Street e City or Town, State)	81. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
۳ II	29e. CERTIFIER (Check only	eath occurre	d at the time, d	ste end plece, end due	to the cause(e) and mer	ner se stated						
<b>∑</b>	one) 2 MEDICAL EXAMINER: On the beele of exemination end/or											
Ö	296. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NUI			SIGNED (Month, Day, Year)					
0	Charles VI, Finzer	,		D05	928	► M	arch 15,1993					
f	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITE	М 27) (Туре,	_		1 4 7		71101					
	31. DATE FUED (Magnin, Day, Your) 32. RIGISTRAP, S SIGNATURE.	^ M	D, A	thnapol	i's, MI	) /	4140					
	31. DATE FILED (MONT), DOY, YOU? 32. REGISTRAT'S SIGNATURE.	Pandell	•	A								



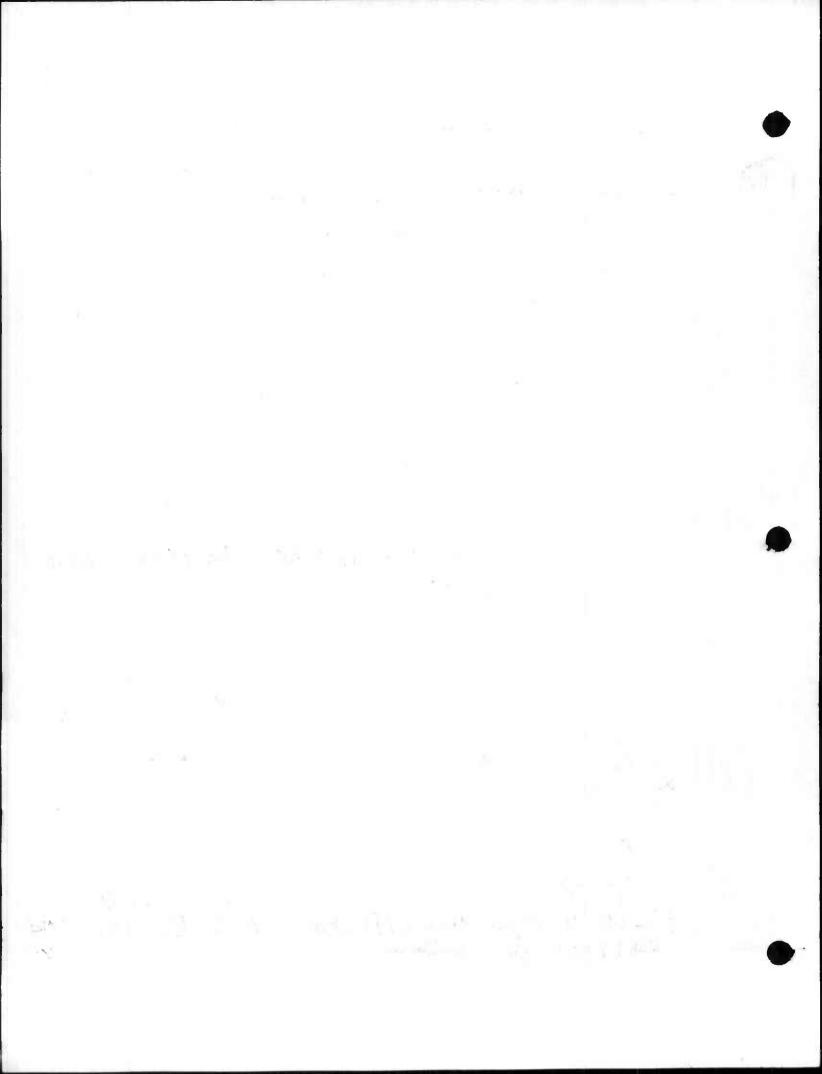
DHMN-18 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

NO
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
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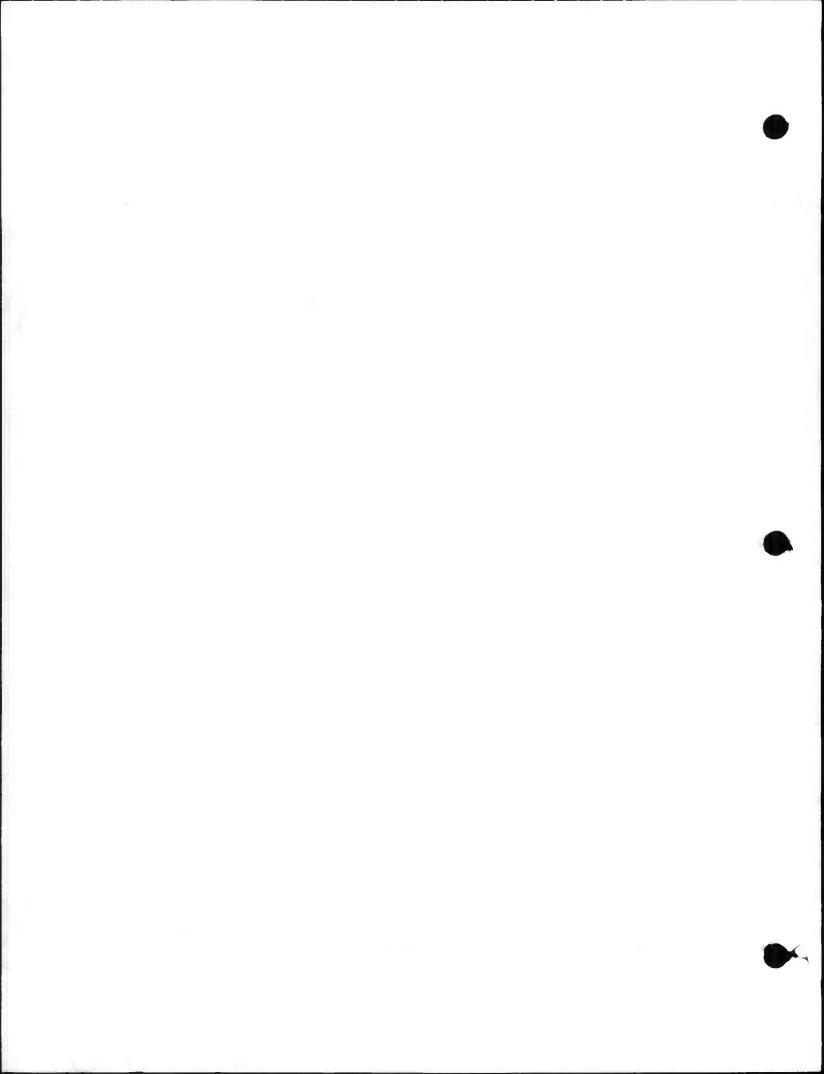
1. DECEDENT'S NAME (First	, Middle, Last)				TOATT	- 01	DLA		2. DATE OF DEATH			3. TIME OF DEATH
RAYMOND		L SA	AFFELL						MONTH DA	"3 1·	993	8:50 A M
4. SOCIAL SECURITY NUM	BER	5. SEX	6. AGE (In yrs. Is	est birthday)	IF UNDER	R 1 YEAR	IF UNDER	9 24 HRS.	7. DATE OF BIRTH			LACE (State or Foreign
577-26-4806		1 M 2 F	68	YRS.	MONTHS	09 25 1924 Virginia						inia
FORT WASHI			CENTER		9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN							
RESIDENCE OF DEC					FORT WASHINGTON PG							
10a. STATE	10b. COUNTY			R .	Y, TOWN		TION NGTO					10d. INSIDE CITY
MD 100. STREET AND NUMBER	The fiffice deorge's											YES 2 NO
8806 OAK L	ANE					100	2074				J.S.A	AT COUNTRY?
11. MARITAL STATUS		12. WAS DECEDEN	TUEVER IN U.S. A	RMED	13.	WAS DEC			C ORIGIN? (Specify Yes			
1 Never Merried 2 💢		FORCES? 1 IF YES, GIVE W	YES 2	NO		If yes, sp	ecifyCube	n, Mexicen	, Puerto Rican, atc.)	OF NO.	Black,	- American Indian, White, etc.
3 Wildowed 4 Divorced WWII 1 YES 2 NO Specify: Specify: White												
15. DEC (Specify only	EDENT'S EDUC highest grade	CATION completed)	(1	ECEDENT'S Give kind of	and done	CCUPATIO	ON let of working	202	16b, KIND OF BUS	SINESS/INC	DUSTRY	
Elementary/Secondary (0	1-12)	College (1-4 or 5 +	1	oofer	se retired.)	auting the	ot or works	79	D C			
8				oorer					Roofi			
Raymond L.		11							IE (First, Middle, Malden	Sumeme)		
19e. INFORMANT'S NAME (1									ude Stump			
Mary J. Sa									oute Number, City or Town			
			20b, PLACE	8806	0ak	La	Ft.	Was	hington. N	Mary1	and 2	0744
20a. METNOD OF DISPOSITI	n 3 🗆 Remo	oval from State	cemetery cr	ematory or o	ther place!			0 /			City or Town	
4 Donottop 5 Other (Specify) Ft. Lincoln Cemetery 3/17/93 Brentwood, Maryland  21. SIGNATIVE OF FUNERAL SERVICE LIPE 22. NAME AND ADDRESS OF FACILITY												
×4000	00 8	DVal	1	/					as Funeral	Hom	e	
Trace	gen	J Mal	Re		6	160	Oxon	Hil'	1 Rd Ovon	H: 11	Md	20745
23. PART I. Enter the di ahock, or he	seeses, or c eart failure. I	omplications the	caused the di sa on asch lin	esth. Don e.	not entar	tha mo	da of dyi	ng, euch	sa cardisc or reeple	ratory err	est,	Approximate interval Between
IMMEDIATE CAUSE (Fin	ai	1	1-				. 1		17	_		Onset and Death
resulting in death)	<b>→</b>	10	ate	My	100	A	DIE	K	/htsi	10		MINO
		1	OR AS A CONSU	QUENCE OF	F): •					/		
Sequantially liet conditi		DUE 16	ON AS A CONSE	OUT NOT OF	n.							
if any, laading to immed cause. Entar UNDERLY!	NG	30000		Water Street	270							i
CAUSE (Disesse or inju- that initiated events	y i	DUE TO	OR AS A CONSE	OUENCE OF	7:							-
resulting in death) LAS	r d											
PART II. Other significa-	nt conditions	contribution to	de ath here are									1
PART II. Other significa	TR CONDITION	contributing to	usath but not	resulting i	n tha un	deriying	cause g	liven in P	art I. 24s. WAS AN / PERFORI		A	VERE AUTOPSY FINDINGS WAILABLE PRIOR TO
									YES 2	□ NO		OMPLETION OF CAUSE OF DEATH?
									_		1	TYES 2 NO
25. WAS CASE REFERRED TO	MEDICAL											
EXAMINER?	MEDIONE	HOSPITAL:			OTHER	t:		EATH (Chec				
27. MANNER OF DEATH		1 Inpatient 2 X		28b. TIME					Other (Specify)			
	ending	(Month, Da		INJ!		_	RK?		28d. DEŞCRIBE NOW IN	JURY OCC	URED	
3 Suleide	2 Accident Investigation											
	Could not be letermined	building, a	rtc. (Specify)		meat, rect	ry, orne	15.00		28f. LOCATION (Street ar City or Town, State)	nd Number	or Rural Rou	ite Number,
290. CERTIFIER 1 CERTI	EVING DUVELO	IAM. To the best of										
(Check only one) 2 MEDIC	CAL EXAMINER	: On the bests of ex	ny knowledge, de emination end/or	lawetleetle	d at the ti	me, date	end place,	end due to	the ceuse(s) end menr	ner es state	id.	
296. NorOTURE OF CREMENTS												
29c. LIGENSE NUMBER 29d. DATE SIGNED (Mogrit, Dey, Yoer)  7/12/62												
30. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH, (ITEM 27) (Type, Print)												
Track M. Jayou M.D. 6/88 (XM) HILLA # NOKOMANIMA												
MAR 1 7 1993 June Davidson-Randalle Zory												



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1	78	2	Patter
			srmit.

BALTIMORE, MARYLAND 21215-0020

		1. DECEDENT'S NAME (First, Middle, Lest)  2. DATE OF DEATH MONTH DAY YEAR  3. TIME OF DEATH													
<b>7</b>		James Cur		1							March		993	11:51 P.M	
		4. SOCIAL SECURITY NUMB		5. SEX		rs. lest birthday) YRS.	IF UNDER	1 YEAR	IF UNDER	24 HRS. MIN,	7. DATE OF BIRTH (Month, Day, Yes	r)	Country		1
pino		579-20-3615 94. FACILITY NAME (If not in		AL	71		9b. CITY	TOWN	OR LOCATI	ON OF DE	10-26-2		Frank	lin, W. Va.	
3	HO.	Doctors Con			a 1				ham,		ain	JE. CO.	P.G		
<b>3)</b>	5	RESIDENCE OF DEC	10b. COUNT	v		10.07	Y, TOWN C						1.0		1
Page	DIRECTOR			Georges		College Park, Marylan					nd			10d. INSIDE CITY LIMITS?  1 X YES 2 NO	
permit		10a, STREET AND NUMBER	LIMCE	COLGES		10011	ege		of, ZIP COD		ind	10g. CF	TIZEN OF W	HAT COUNTRY?	1
physician. burlal-transit permit. Page	FUNERAL	9014 Rhode I	sland				_			740			L		
physician. burial-trar		11. MARITAL STATUS 1 Never Married 2 K	Married	12. WAS DECEOENT EVER IN U.S. ARMEO FORCES? 1 A YES 2 NO IF YES, GIVE WAR OR DATES				If yes, a	pecify Cubs	n, Mexican	IC ORIGIN? (Specif n, Puerto Rican, etc	y Yes or No—	14. RACE Black,	- American Indian, White, etc.	1
attending p	BY	3 Widowed 4 Divo	rood	AR OR DATE	R DATES 1 TYES 2 AL NO Spec					:	White	L			
al or atter for use a:	ETED		EDENT'S EDU highest grade								16b, KIND OF	BUSINESS/IN	DUSTRY	WHILE	1
pital o	PLE	Elementary/Secondary (0	-12)	College (1-4 or 5 +	)	ille. Do NOT us						7.7			
the hospital detached fo	COMPL	17. FATHER'S NAME (First, M	iddle, Last)			Ins	tallo	er	18. MOT	HER'S NAM	ME (First, Middle, Ma	rywall iden Surname)			1
5 2 E	5 m 3	Edwin P. S	Simmon	S					-C.A 1 F 7		Meadows				
should should notified	TO B	19a. INFORMANT'S NAME (7)				19b. MAILING	ADDRESS	(Street			loute Number, City or	Town, State, Z	ip Code)		1
		Beulah I.								Ave.				ark. Md.2074	40
9 8 3		20a, METHOD OF DISPOSITI 1 M Burlal 2 Crematio 4 Donation 8 Other	n 3 🗆 Rem (Specify)	oval from State	cometer	ACE AND DATE OF OF OR THE TAIL TO CO	ther placel			3_1	1	LOCATION -		,	
ral direc		Fort Lincoln Cemetery 3-15-93 Brentwood, Maryland  21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY Fort Lincoln Funeral Home, Inc.													1
		Shan	NON	10.40	imi	ne)					rg Rd.Bi			. 20722	
ours after d d in by the i or removal.		23. PART i. Enter the di shock, or he	seases, or c	complications that List only one caus	caused th	e death. Do r	not enter	the m	ode of dy	ing, such	as cardiac or n	espiratory a	rrest,	Approximate	1
2 20 6		IMMEDIATE CAUSE (Fin	ai											Onset and Death	ı
completely file ial, cremation, event, the		resulting in death)	<b>→</b>	a. MYO	CARD	HAL I	VFA	RC	TIDI	N, A	CUTE				L
2 5 ± 6	z			GAST	1200-	INITES	TIAL A	1.	HEMI	2001	JACKS A	NITE		i	Г
8 O E	CERTIFICATION	Sequentially list conditions, If any leading to immediate Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):											1		
certificate be ding physicial fygiene prior r other trau	FIC	CAUSE (Disease or Injury that injured exercises  DUE TO (OR AS A CONSEQUENCE OF):													1
	E	that initiated events  DUE TO (OR AS A CONSEQUENCE OF):  resulting in death) LAST													
the death y the atten nd Mental H	1	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY FINDINGS											1		
T do	MEDICAL			N, OLD			ir the un	oenyn	ig cause (	jiveii ili r	PEF	AN AUTOPSY FORMED?		WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE	L
sign Sign Healt	ME I		111111111111111111111111111111111111111	,							¹ U YE	S 2 X NO	- 1	OF DEATH?	
law requast been bept. of 23 sho															ı
PHYSICIAN: The law req this certificate has been with the State Dept. of rked, or Item 23 sh	PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:			OTHER	t:	LACE OF O						1
Sicial certification the Single Sicial Certification the Single Sicial S	HYS	1 X YES 2 NO 27. MANNER OF CEATH		1 Inpetient 2 I	INJURY	28b. TIM	E OF		JURY AT	sidence (	28d. DESCRIBE HO	W INJURY OC	CURED		1
NG PHYS fler this cath with marked	ВУ Р	1 Natural 5 1	Pending investigation	(Month, Da	y, Year)	INJ	M		ORK? YES 2	] NO					
IS A S	8	3 Suicide 8 🔲	Could not be	28e. PLACE OF building, a	INJURY — . Nc. (Specify)	Al home, farm, s	street, fact	ory, offi	ce		281. LOCATION (St. City or Town, S		or Or Rural Ro	oute Number,	1
DIRECTOR DIRECTOR Dours afte	<b>□</b>	An CERTIFIER													
# 28 F	COMPL	(Check only		CIAN: To the best of a										and manner as stated.	
TO THE HOSPITAL TO THE FUNERAL IS BE filed within 72 h	. 11	29b. SIGNATURE AND TITLE	OF CERTIFIER	3		- Investigatio	at, in my o	prinori,	T 200 LICE	MOE MINE	nme, date and place	, and due to t	ne cause(s)		
THE OF THE OF SIGN	BE	AllSmy	nc MD						D2	592	25	≥ /V	VAR 11	Month, Day, Year) , 1993	
	2	30. NAME AND ADDRESS OF	PERSON WH	O COMPLETED CAUS	E OF DEATH	(ITEM 27) (Type,	Print)		-	0	10.			1.00	1
101	)		GER,	#205,	120	Wisco	NSIN	A	ive, B	elke	sda md	2001	14		
		31. DATE FILED (MONTH), Day, 1	<b>6</b> 1993	0 COMPLETED CAUS # 205 " 32. REGISTRAI	Davids	n- Mande	22								

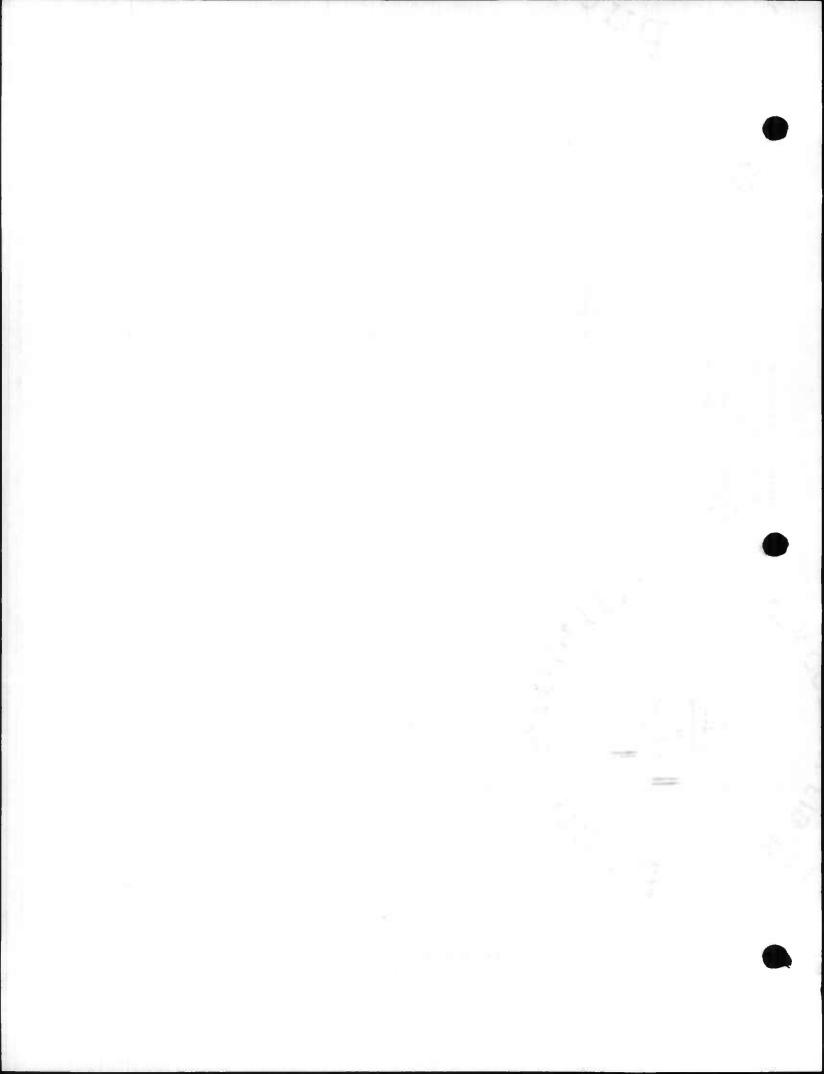


BALTIMORE, MARYLAND 21215-0020	s after death. Page 6 may be retained by the hospital or attending physician.	by the funeral director, page 5 should be detached for use as the burial-transit permemoval.	lical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HISPITAL OF MITENDING PHYSICIAM: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL CHECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit be filed within 72 hours after death with the State Debt, of Health and Mental Hypiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

100

ITEMS: 25, 27 28a,c,d,e,f, PER MEO 5/27/93 t.t/s.w STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE FOR

REGISTRAR		CERTIF	CATE O	F DEATH	REG. N	0.						
1. DECEDENT'S NAME (First, Middle, Lest)					2. DATE OF DEATH MONTH	DAY	YEAR 3.	TIME OF DEATH				
	EDEM (Elre		rt Sne	den)	3 1		3	9P 1				
450-07-0925	XM 2 □ F	(In yrs. last birthday)	MONTHS DAY	B HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 07/30/19	1	Country)	nam, VT				
9a. FACILITY NAME (If not institution, give stree 6317 Sligo Parkwa RESIDENCE OF DECEMENT		=2000		n or location of d ttsville	EATH		TY OF DEAT	eorge's				
10a. STATE 10b. COUNTY			r, TOWN OR LO				10	d. INSIDE CITY LIMITS?				
	George's	Ну	<u>attsvil</u>			,		☐ YES 2 X NO				
6317 Sligo Parkwa				20782		1.1.	S.A.	T COUNTRY?				
3 Widowed 4 Divorced	2. WAS DECEDENT EVER II FORCES? 1 1 YES IF YES, GIVE WAR OR D	2 XINO	If yes		NIC ORIGIN? (Specify Year, Puerto Rican, etc.)		14. RACE — Black, W Specify:	American Indian, hita, etc. White				
15. DECEDENT'S EDUCAT (Specify only highest grade co.	TON mplated)	16a. DECEDENT'S			16b. KIND OF B	USINESS/INDU	JSTRY					
	Elementary/Secondary (0-12) College (1-4 or 5 +) life. Do NOT use retired.)											
17. FATHER'S NAME (First, Middle, Last)												
Carl James Sneder	Carl James Sneden Lizzie M. Thaxter											
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Stre	et and Number or Rural	Route Number, City or To	wn, State, Zip (	Code)					
Karen Sneden		908 C	arroll	Avenue,	Laurel, N	lar ylaı	nd 20	707				
20a. METHOD OF DISPOSITION 1 Buriel 2 Cremetion 3 Remove	20s. METHOD OF DISPOSITION 1											
4 Donation 5 Other (Specify)	M	etropolita	an Cre	matory 03	3/14/93 AI	exand	ria, '	Virginia				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  Francis Gasch's Sons Funeral Home, P. 4739 Baltimore Avenue, Hyattsville, ME												
23. PART I. Enter the diseases, or cor		d the death. Do n	ot enter the	mode of dving suc	th as cardiac or rea	, Hyd	LLSVII	Approximate				
shock, or heert fellure. Lis	it only one ceuse on e	ach line.	or onto the	mode of dying, sac	in as caldiac or les	phatoly arre	rent,	interval Between				
disease or condition												
resulting in death) a	resulting in death)  a. PNEVMONIA  DUE TO (OR AS A CONSEQUENCE OF):											
z .												
Sequentially list conditions,	If any, leading to immediate											
Cause. Enter UNDERLYING												
that initiated events	that initiated events OUE TO (DR AS A CONSEDUENCE OF):											
resulting in death) LAS1	resulting in death) LAST											
PART ii. Other significant conditions of	contributing to death t	out not requiting i	n the underly	ring cause given in	Part I. 24a WAS A	N AUTOPSY	24h WE	RE AUTOPSY FINDINGS				
S SENILE DEMENT					PERF	PAMED?	AM	ALABLE PRIOR TO MPLETION OF CAUSE				
APHEROSCLERDTI		2 1			1 🗆 YES	2 XNO	OF	DEATH?				
				2			1 (	YES 2 NO				
FALLS WITH SUBS	URAC HYGR	OMA AND		PLACE OF DEATH (C)								
EXAMINER?	IOSPITAL:	2021 . D an	OTHER:									
ZY FALLS UITH SUBJ 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES ZAMO  27. MANNER OF DEATH	28a. DATE DF INJURY	26b. TIMI		INJURY AT	5 ☐ Other (Specify)  28d. OE\$CRIBE HOW	IN ILIBA UCCI	IRED					
	(Month, Day, Year) 1 - 26 - 93	ТИЛ	URY	WORK?  YES 2 \( \backsquare \) NO	SUBJECT		ONLO					
	26s, PLACE OF INJURY	— At home, term, s		,,,,,	261, LOCATION (Stree	t and Number o	or Rural Route	Number				
G Gold not be detarmined  29s. CERTIFIER (Check only one)  2 MEDICAL EXAMINER:	building, etc. (Spec	HOME			261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 3 1 7 S 1 1 9 0 P k w y .							
29a. CERTIFIER 1 CERTIFYING PHYSICIA	M: To the heat of my trees		4 4 4 4 4 4		Hvattsvil							
(Check only one) 2 MEDICAL EXAMINER:								d manner on stated				
m T T				29c. LICENSE NUI		29d. DATE	SIGNED (M	onth, Day, Year)				
a lu manage	OMPLETED CALLES DE DE	ATM (ITEM OR /E	(Period)	022	780	3/	11/7.	)				
Peter M Schissles	~ MO 7500	Oreen:	way (7	r. Dr. O	reenself	MOZ	077	0				
MAR 1 2 1993	32. REGISTRAR'S SIGN	Adon-Rand	100									



		FOR
1	-	STATE
•		REGISTRAR

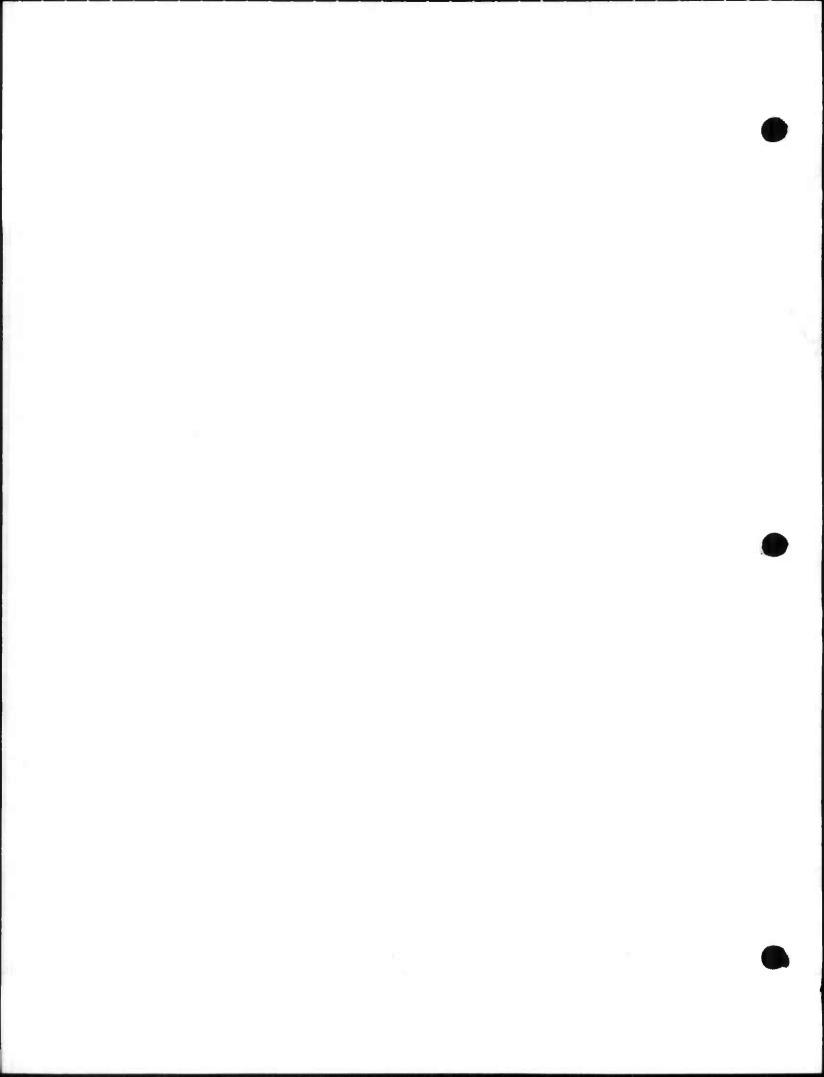
	1 - STATE REGISTRAR	SIAIE UP MA			ICATE					TUIENE EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)									EATH DAY	,	YEAR	3. TIME OF DEATH
			. SMITH						March 1, 1993				7:25 P.M. M
	4. SOCIAL SECURITY NUMBER	5. SEX (	S. AGE (In yrs. last	YRS.	IF UNDER	1 YEAR DAYS	HOURS	MIN.	7. DATE OF BIRTH (Month, Day, Year)			8. BIRTHI Country	PLACE (State or Foreign
	9a. FACILITY NAME (If not institution, give s	4	90	Tho.	Ab CITY	TOWAL O	B L OCATY	ON OF DEAT	May 14	1,190	9c. COU	land	
H	429 West Patr		t		MA CITY		deri			Α.		ederi	
5	RESIDENCE OF DECEDENT							·CK				- CCLL	.ck
DIRECTOR	100. STATE 100. COUNTY 100. CITY, TOWN OR LOCATION  Maryland Frederick Thurmont											10d. INSIDE CITY LIMITS?	
	Maryland Fre		nt ZIP CODE				10- 07	1 YES 2 NO					
ERA	7549 Utica R	Road				101.		788			log. Cit	U.S.	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. ARM	ED	13.	WAS DECE	NDENT O	F HISPANIC	ORIGIN? (Sp	ecify Yes	or No—	14. RACE	- American Indian.
BY F	1 Never Married 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAI	YES 2 THO	)				Specify:	Puerto Rican,	, etc.)		Specif.	white, etc.  White
ED	15. DECEDENT'S EDU		16a. DEC	EDENTS	USUAL O	CCUPATIO	N .		16b. KINE	OF BUS	INESS/INC	DUSTRY	MILCE
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Gha life, L	kind of to NOT us	work done ( se retired.)	during mos	t of working	g					
MP	7			Н	omema	ker				Но	ome		
	17. FATHER'S NAME (First, Middle, Last)		TT. 1 4						(First, Middle		,	. 1 .	
B	19a. INFORMANT'S NAME (Type/Print)	Eugene	Ho1t	MANIBO	1000000	(0)			Cather				
5	Mrs. Mildred E. H	Jouri t t	- 1						ont, N	-		,	
	20a. METHOD OF DISPOSITION		20b. PLACE AN	ID DATE	OF DISPOS	_		патик	DATE			City or Tox	wn, State
	1 Denation 5 Other (Specify)		Lewist	etory or o	ther place)	terv	. 3-	4-93		Lewi	isto	wn. M	Maryland
- 1	21. SIGNATURE OF FUNERAL SERVICE LIC								ITY				
- ()		L Ruby		0703	3 110	16 Ea	et C	hurch	rd P.A n St	Fre	dor.	ick	ome Md. 21701
	23. PART I. Enter the diseases, or o shock, or heart failure.	omplications that of	caused the dear	th. Do i	not enter	the mod	le of dyle	ng, such a	na cardiac (	or respir	atory an	rest,	Approximate Interval Between
	IMMEDIATE CAUSE (Final	The same of the sa		_	/		_						Onset and Death
	resulting in death)	a. CORSY	MAY A CONSECU	14A	SM D	21/7	)	_					yens yens
_	The Contraction of the Contracti												
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (C	AS A CONSEQU	ENCE O	F):								1
2	CAUSE (Disease or Injury	C											
Ē	that initiated events resulting in death) LAST	DOE 10 (0	R AS A CONSEQU	IENCE O	F):								
		J											
ICAL	PART II. Other significant condition				In the un		cause g	iven in Pa	irt I. 24a.	WAS AN A		24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
		7,7000		71/	ara				_ 1□	YES 2	NO		OF DEATH?
Σ							-		-		•		1 TYES 2 THO
PHYSICIAN: MED	25. WAS CASE REFERRED TO MEDICAL					26. PL/	ACE OF DE	EATH (Check	only one)				
Sic	EXAMINER? 1 YES 2 () NO	HOSPITAL;	ER/Outpatient 3	DOA	OTHER		5 🗆 Re	sidence 6	Other (Spe	icify)			
듄	27. MANNER OF DEATH	26e. DATE OF IN (Month, Day,		28b. TIM		28c. INJU WOR	RY AT		8d. DESCRIB		JURY OC	CURED	
BY	1 Natural 5 Pending 2 Accident Investigation				М	1 🗌 YI	ES 2	NO					
	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF building, et	INJURY — At hom c. (Specify)	e, farm, :	street, fact	ory, office		2	61. LOCATION City or Tow	l (Street er vn, State)	nd Number	r or Aural A	oute Number,
ᄪ	20- 05075570												
COMPLETED	(Check only												ALEXANDER DE LA CONTRACTOR DE LA CONTRAC
	29b. SIGNATURE AND TITUE OF CERTIFIES		miniation and/or an	reatigatio	m, in my o	pinion, de				place, and	due to th	he cause(e)	end manner as stated.
BE		MO						NSE NUMBE		-	29d. DAT		(Month, Day, Year)
임	30. NAME AND ADDRESS OF PERSON WH	D COMPLETED CAUSE	OF DEATH (ITEM	27) (Type	, Print)		$\mathcal{O}$	50 1	152		,	3/-/	. ,
	180 Thos.	Johns		1ve	-	FA	ela	reh	1	10			
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR							<u></u>				
	MAR 0 3 199	J guna Di	widson-Ro	ndell	6								

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the funishments be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DHMH-16 Rev 1/89



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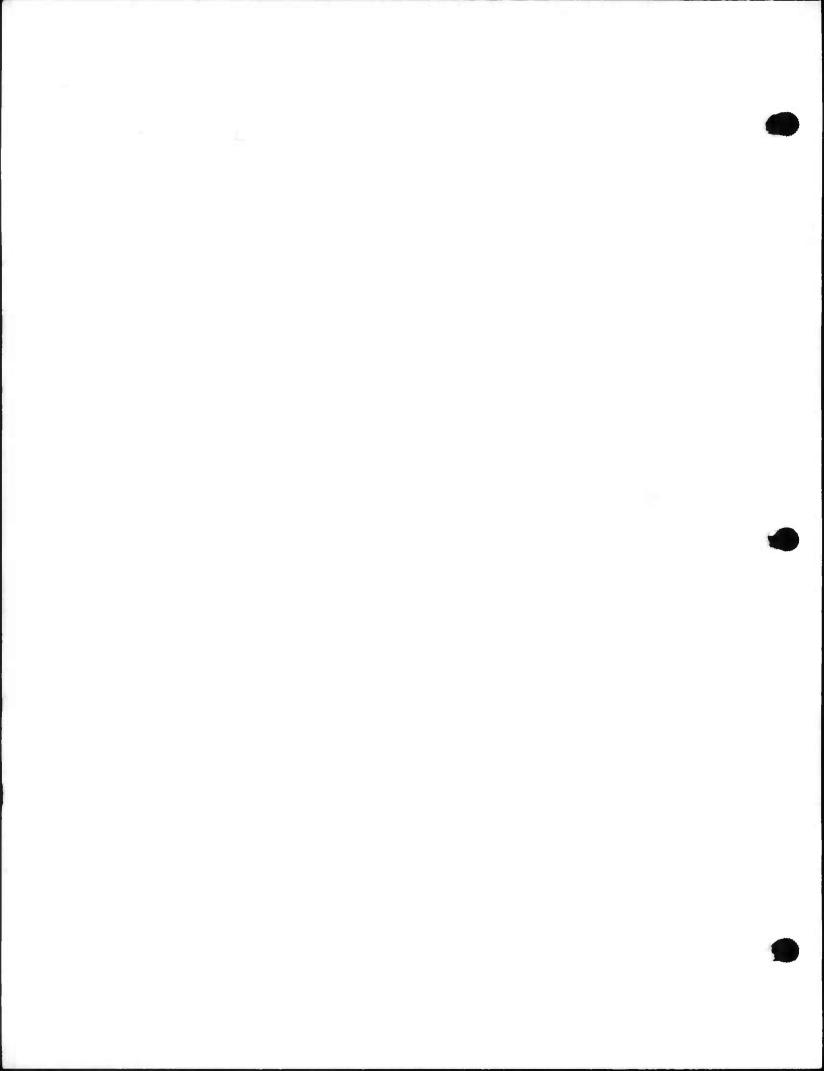
BALTIMORE, MARYLAND 21203	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an four after death. Page 6 may be retained by the hospital or atter	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use a	Val.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
. BOX 13146,	rithcate be executed within and	ng physician and completely filled in by	gene prior to bunal, cremation, or remi	other traumatic event, the medic
DIVISION OF VITAL RECORDS, P.O. BOX 13146,	CIAN: The law requires that the death co	ertificate has been signed by the attendi	the State Dept. of Health and Mental Hy	or item 23 shows any injury, or
DIVISION OF	TO THE HOSPITAL OR ATTENDING PHYSH	TO THE FUNERAL DIRECTOR: After this co	be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to bunal, cremation, or removal.	iMPORTANT: if item 28 is marked,

	FOR STATE REGISTRAR	STATE OF 1		ERTIF					ENTAL	HYGIEN REG. NO.	<b>E</b> 9	3 (	09514
	1. DECEDENT'S NAME (First, Middle, Last)	EMMA	SUNDERG		3.0		,		2. DATE O	F DEATH DA	y _y	EAR 3.	TIME OF DEATH
	EMMA				NOR				3	_ 3	9		3:50 A M
	4. SOCIAL SECURITY NUMBER 214-10-1450	5. SEX 1 ☐ M 2 1 F	6. AGE (In yrs. le	st birthday) YRS.	IF UNDER	DAYS	IF UNDER	MIN,		F BIRTH Day, Year) 0-03	٨	Country) Waryl	
TOR R	98. FACILITY NAME (It not institution, give street and number)  96. COUNTY OF DEATH  Meridian Nursing Home  Frederick  Frederick  Frederick												
<u></u> [													I. INSIDE CITY
DIRECTOR	Maryland Frederick Frederick X											LIMITS? YES 2 NO	
FUNERAL	100. STREET AND NUMBER 721 Trail Avenue 107. ZIP CODE 21701 USA											COUNTRY?	
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	1 Never Married 2 Married FORCES? 1 YES 2 NO If yes, specify Cuban, Mexican, Puerto Rican, etc.)  Black, W. Specify: Spe											American Indian, hita, etc. White
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working like. Do NOT use retired.)  Homemaker												
BE COM	17. FATHER'S NAME (First, Middle, Last) William C. Sapp	ington						HER'S NAM		iddle, Maiden 2ly	Surname)		
TO B	19a. INFORMANT'S NAME (Type/Print) Mrs. Mary Gambl	e	19								n, State, Zip Co		
	20e. METHOD OF DISPOSITION 1 D/Buriel 2 Cremetion 3 Remote Proceedings of Control Cont	oval from State		of oispoi				matory or			cation — cir ederic		
	21. SIGNATURE OF FUNERAL SERVICE LIC	D.S	- Land	)							ick, Mi		02
	PART I. Enter the diseases, prospective in the control of the cont	List only one ca	use on aach lin	ie.						sc or reep	ratory erree	t,	Approximate interval Between Onset and Death
	resulting in death)		COR AS A CONSI					3C6					
ATION	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO	OR AS A CONS	EQUENCE O	F):								
CERTIFICATION	CAUSE (Disease or injury thet initiated events resulting in dasth) LAST	DUE TO	O (OR AS A CONSI	EQUENCE O	<b>f</b> ):								
PHYSICIAN: MEDICAL C	PART ii. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I.   24a. WAS AN AUTOPSY   24b. V											CO OF	RE AUTOPSY FINDINGS ALLABLE PRIOR TO MPLETION OF CAUSE DEATH?  YES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL					26. PI	ACE OF I	DEATH (Chec	ck only one	)		1	
200	EXAMINER?  1   YES 2   NO	HOSPITAL:	☐ ER/Outpatient	3   DOA	OTHE!	R.		esidence 8					
	27. MANNER OF DEATH  1	28a. DATE O		28b. TIN		28c. INJ WC	URY AT ORK? YES 2				NJURY OCCU	RED	
TED BY	2 Accident investigation 3 Suicide 8 Could not be 4 Homicide detarmined	28s. PLACE building	OF INJURY — At I	nome, farm,	street, fac	tory, offic	•			TION (Street or Town, State)	and Number or	Rural Rout	Number,
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSI one) 2 MEDICAL EXAMINE												d manner as stated.
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIE	1.h	inc		Mo	,	29c. LIC	ENSE NUM	BER 5	)	29d. DATE S	SIGNED/(MG	onth, pay, Year)
H-	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAL	ICE OF DEATH OF	THE DW /T-	Philad								1

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (IFEM 27) (Type, Print)

1993

22. REGISTRAN'S SIGNATURE POLICE



BALTIMORE, MARYLAND 21215-0020

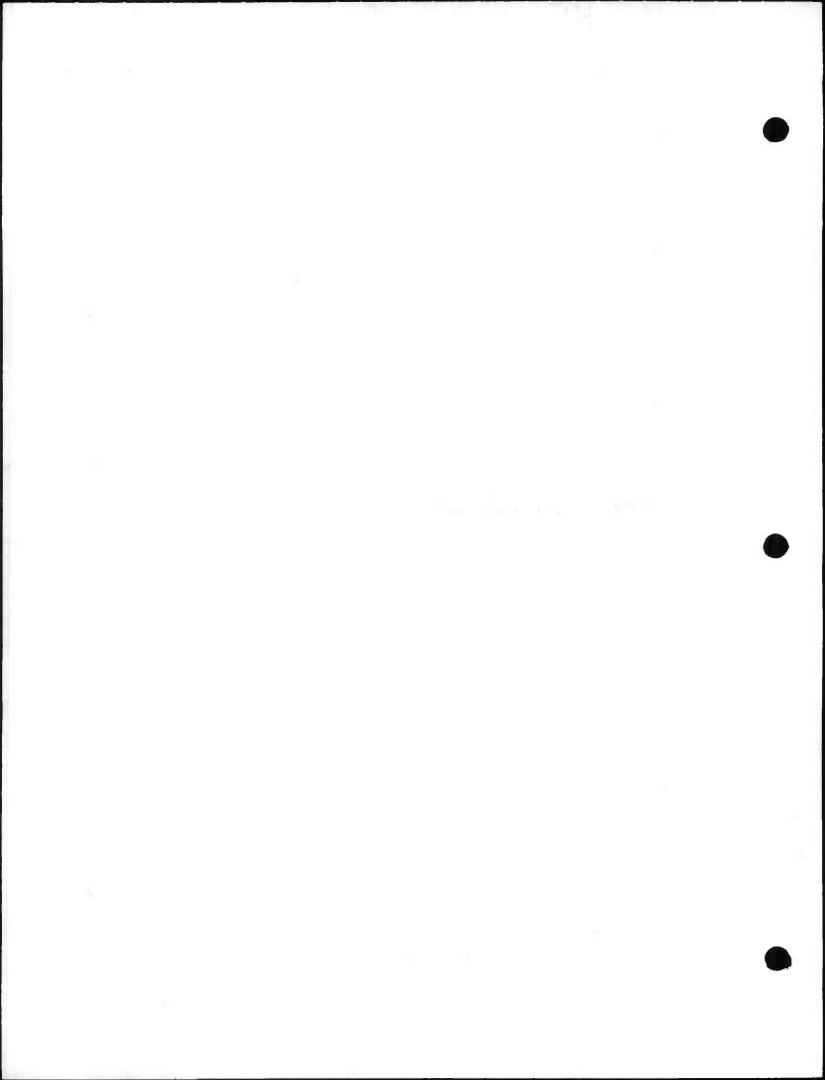
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNEPAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO BE COMPLETED BY FUNERAL DIRECTOR

Ι, PER MEO G-699 ITEM: 23 PART 5/5/93 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1 - STATE REGISTRAR	STA	ATE OF MAR	RYLAND C	DEPARTI	MENT O	F HEALTH AND	MEN1	TAL HYGIENI REG. NO.			0 ) 0		
1. DECEDENT'S NAME (First, Middle, L	est)				J. DEATH	2. D/	3. TIME OF DEA	TH.					
STEVEN-Stephe	en Ma	ark S	IMMS JR.					3 DAY		93	1:26	Рм	
4. SOCIAL SECURITY NUMBER	5. SE	K 6. /	AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS					TE OF BIRTH	_	A. BIRTI	IPLACE (State or Fi		
216-37-6339	1 🔀	M 2 🗆 F		YRS.		4 HOURS MIN.	No	onth, Day, Year) V. 19.1	992		Country) Marvland		
9a. FACILITY NAME (If not institution, g	ive street and	number)		9		WN OR LOCATION OF E	4 10 1 4	· · · · ·	9c. COUN				
FREDERICK M	EMOR]	IAL HO	SPITA	AL	FR	EDERICK			FRE	DEF	RICK		
RESIDENCE OF DECEDENT 10a. STATE 10b. CO				I son CITY :	2011001	00171011							
Maryland Frederick Frederick											10d, INSIDE CITY LIMITS?		
100. STREET AND NUMBER 101. ZIP CODE 109. CITIZEN OF WHAT											1 X YES 2 _	NO	
500 North Bentz	Stro	ot And	rtmor	+ 50		21 701			10g. CITIZ				
11. MARITAL STATUS	12. W	S DECEDENT EV	ED IN HS A	DMED	T 42 WHG				Т		S.A.		
1 Never Married 2 Married 3 Widowed 4 Divorced	FO	PRCES? 1 1 YES, GIVE WAR	YES 2 🔽	NO	If ye	a, specify Cuban, Maxic YES 2 X NO Speci	an, Puer	GIN? (Specify Yea to Rican, atc.)	or No-	14. RACI Blac Spec	E — American Indi k, White, etc. "Y" White	ın,	
15. DECEDENT'S (Specify only highest of		ard)		ECEDENT'S US			1	16b. KIND OF BUS	INESS/INDU	USTRY		$\neg \neg$	
Elementary/Secondary (0-12)		ge (1-4 or 5 +)	- in	s. Do NOT use n	t done duni stired.)	ng most of working							
Ø													
17. FATHER'S NAME (First, Middle, Last,								st, Middle, Maiden S	Sumame)				
Stephen Mar	k	SIMMS		r	_	Sheil		Dawn		ALM	ER		
19a. INFORMANT'S NAME (Type/Print)						reet and Number or Rural							
Stephen M. Simm	ns, Sr					z St, Apt.	50	, Frede	cick,	MD	21701		
20s. METHOD OF DISPOSITION 1X Burlal 2 □ Cremation 3 □ 1	Ramoval fro	m State	comoton, o-	AND DATE OF I	mlanat	7.			ATION — C				
4 Donation 5 Other (Specify) _ 21. SIGNATURE DEFUNERAL SERVICE	E i unmunes		Rest	haven	Memo:	rial Gar 3	1/6/	93 Fre	ederi	ck,	Marylan	d	
1. share of the device	E LICENSEE	111			Kee	ney & Bast	OTC	P A Fo	mara	1 н	Oma		
Kith home	n	Cobers	YOU M	100706		East Chur						1701	
23. PART I. Enter the diseases,	or complic	ations that ce	used tha d	eath. Do not	enter the	mode of dying, suc	ch aa c	ardiac or reapir	atory arre	est,	Approxim		
shock, or heart falls	ire. List on	IV one cause of	on each lin						-		Interval B	etween	
disease or condition	- S	udde	KUNC	HUPIYE	UNION	Syndron	0.50				Onast and	- Coulin	
reaulting in death)	8.	DUE TO (OR	AS A CONSE	OUENCE OF):	un	Synator	re						
Variable Sales											İ		
Sequentially list conditions, if any, leading to immediate		DUE TO (OR	AS A CONSE	OUENCE OF):							-		
cause. Enter UNDERLYING CAUSE (Disease or Injury	С												
that initiated events		DUE TO (OR	AS A CONSEQUENCE OF:										
resulting in deeth) LAST	d												
PART II. Other algnificant condi	tiona contr	ributing to dee	th but not	resulting in 1	he under	iving cause given in	Part I.	24s. WAS AN A	UTOPSY	246	. WERE AUTOPSY FI	MDINGS	
					1211000214	,,		PERFORM	EO?	1.40	AVAILABLE PRIOR	TO	
				74	-4		_	1 XYES 2	□ NO		DF DEATH?	AUSE	
				p. 1	. 24						1 X YES 2	10	
25. WAS CASE REFERRED TO MEDICA					-	B BLACE OF DEATH (C)	ha-6			1	24 1		
EXAMINER? XX YES 2 \( \square\) NO		PITAL: patient 2XXER/	10-11	0	THER:	8. PLACE OF DEATH (C/							
27. MANNER OF DEATH		Ba. DATE OF INJU		26b. TIME O		Home 5 Residence							
1 Netural 5 Pending		(Month, Day, Ye		INJUR	/	WORK?	284. 0	DEŞCRIBE HOW IN	JURY OCCI	URED		- 1	
2 Accident Investigati		Be. PLACE OF INJ	IIIOV ALI	in to the		YES 2 NO							
3 Suicide 6 Could not determined	D-G	building, stc.	(Specify)	onie, term, stre	it, tectory,	ornice	261. Li	OCATION (Street and ity or Town, State)	d Number o	or Rural F	loute Number,	- 1	
29e, CERTIFIER												-	
						date and place, and due							
		e Daste of axamir	nation and/or	Investigation, I	n my opini	on, death occured at the	time, de	ate and place, and	dua to the	Cause(e	) and manner ee s	ated.	
296. SIGNATURE AND TITLE OF CENTS	PIER -	( h 44 -				29c. LICENSE NU					(Month, Day, Year)		
Monsed to	Nug	IN MI	2			O.C.M	L.E		▶ 0	3	04- 19	993	
		M.D.				EET BALT	IMC	RE, MAR	YLAN	ND :	21201	$\neg$	
31. DATE FILED (Moort), Day, Year)	1 2 1 .	REGISTRAR'S	SIGNATURE									$\neg$	
												1	



1. DECEDENT'S NAME (First, Middle, Last)

4. SOCIAL SECURITY NUMBER

216-14-6016

8. AGE (In yrs. lest birthday)

77

IF UNDER 1 YEAR | IF UNDER 24 HRS.

HOURS

10f. ZIP CODE

Sier

YRS.

2. DATE OF DEATH March 4. 1993

10d. INSIDE CITY

7. DATE OF BIRTH June 3, 1915

8. BIRTHPLACE (State or Foreign Maryland

96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Frederick Frederick

8826 Reichs Ford Road RESIDENCE OF DECEDENT 16b. COUNTY

9a. FACILITY NAME (If not institution, give street and number

Bernard

Frederick

5. SEX

1 M 2 | F

10c. CITY, TOWN OR LOCATION Frederick

1 YES 2X ND 10g. CITIZEN OF WHAT COUNTRY?

10s. STREET AND NUMBER

Maryland

11. MARITAL STATUS

DIRECTOR

FUNERAL

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MEDICAL CERTIFICATION

PHYSICIAN:

BY

COMPLETED

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8826 Reichs Ford Road 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO 3/25/1941-9/22/1945

Franklin

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify:

21701

U.S.A. 14. RACE — American Indian, Black, Whits, etc. Specify: White

3 Widowed 4 Divorced

1 Never Married 2 X Marrie

15. DECEDENT'S EDUCATION (Specify only highest grade complete College (1-4 or 5+) 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)

16b. KIND OF BUSINESS/INDUSTRY

dery (0-12) 6 17. FATHER'S NAME (First, Middle, Last)

Machine Operator

American Optical 16. MOTHER'S NAME (First, Middle, Maiden Surname)

Walter

19a. INFORMANT'S NAME (Type/Print)

SIER

Margaret

Mrs. Gloria M. Sier

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8826 Reichs Ford Rd, Frederick, MD 21701

3/8/93

20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Stats DATE

22. NAME AND ADDRESS OF FACILITY

20a. METHOD OF DISPOSITION
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

Mount Olivet Cemetery

Frederick, Maryland

21. SIGNATURE OF FUNERAL BETWICE LICENSEE

Lobern

Keeney & Basford P.A. Funeral Home Aceney & Basiord F.A. Funeral 106 East Church St. Frederick 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft fellure. List only one ceuse on each line. 106 East Church St, Frederick,

**IMMEDIATE CAUSE (Final** disease or condition\_ resulting in death)

RESPIRATORY DUE TO (OR AS A CONSEQUENCE OF).

ULMONARY

DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF):

ARTERIOSCLEROTIC CARDIO - VASCULAR DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY 1 TYES 2 TYNO

24b. WERE AUTOPSY FINDINGS AMAII ARI E PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO

Approximate Interval Between

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 TYES 2 NO

27. MANNER OF DEATH

1 Natural

2 Accident

3 Sulcide

28a. DATE OF INJURY (Month, Day, Year)

26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpetient 2 | ER/Outpatient 3 | DOA OTHER: 4 🗆 Nurs 28b. TIME OF

me 5 Residence 6 - Other (Specify)

D10587

28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO

4 Homicide

5 Pending Investigation

6 Could not be

26s. PLACE DF INJURY — At home, farm, street, factory, offics building, stc. (Specify)

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

March 5, 1993

29e. CERTIFIER

(Check only

1 🗵 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, dats and place, and due to the cause(e) and menner as stated. 2 🗋 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

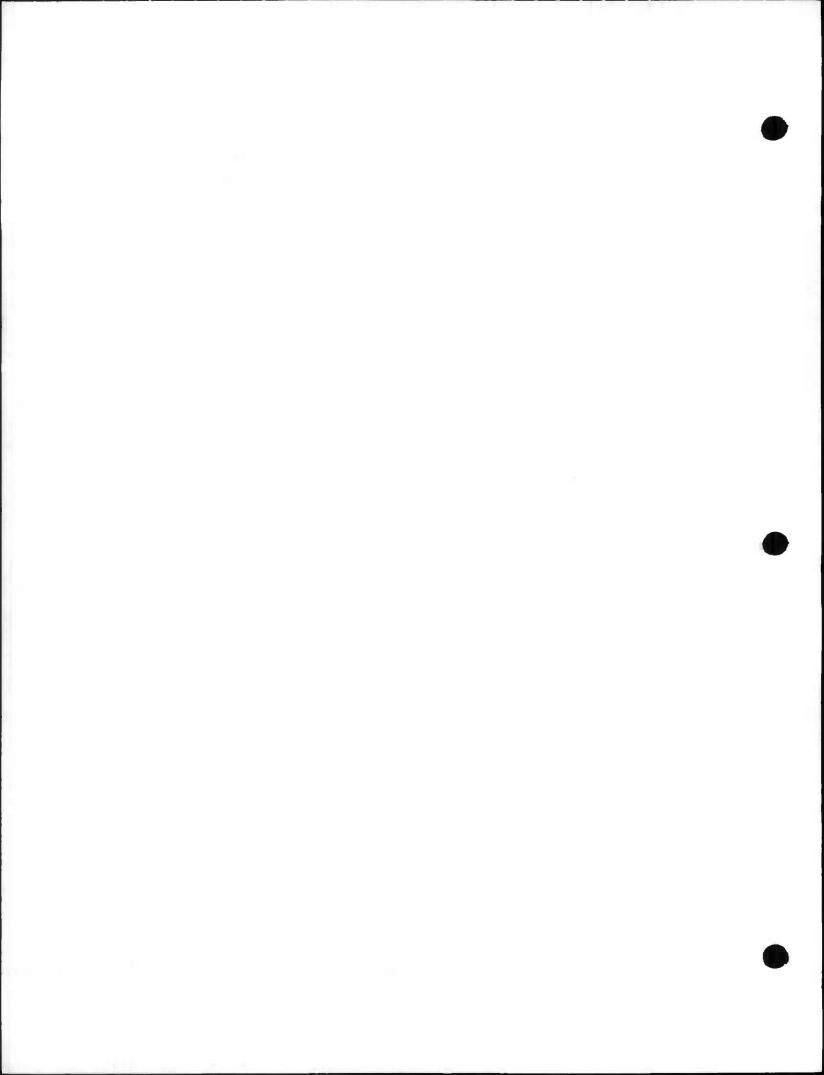
29b. SIGNATURE AND TITLE DF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Yesr)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

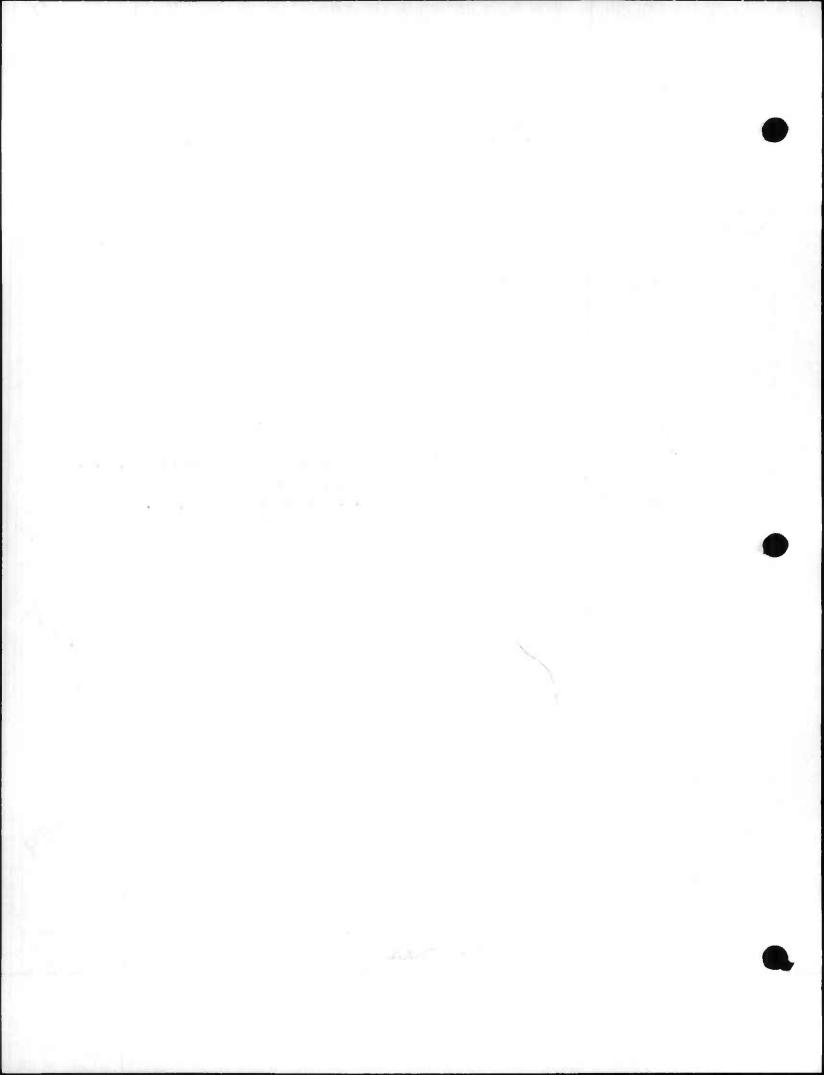
Jr, M.D., 300 West Ninth Street, Frederick, Maryland 21701 George I. Smith,

31. DATE FILED (Month, Day, Year) MAR 0 8 1993 32. REGISTRAR'S SIGNATURE Lika Luydson-Randall

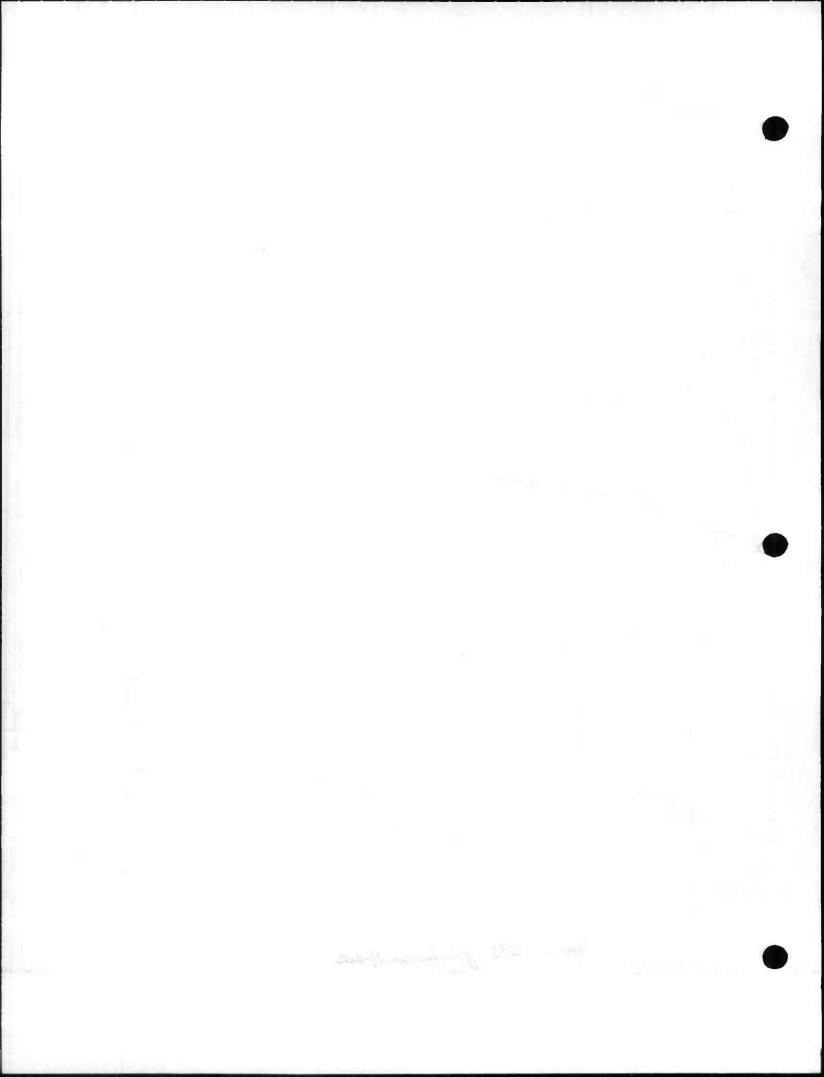
hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 filled in by the funeral director, page 5 should be signed by the attending physician and completely fille Health and Mental Hyglene prior to burial, cremation, executed within RECORDS, P.O. BOX 68760, has been s HOSPITAL DR ATTENDING PHYSICIAN: The law DIVISION OF VITAL DIRECTOR: After this certificate I hours after death with the State TO THE HOSPITAL OF TO THE FUNERAL DE FILED WITHIN 72 hr



	1. DECEDENT'S NAME (First		MARION CI	MCO SHO	LIEDC					2. DATE OF MONTH	DEATH DA	W	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUM	6. AGE (in yrs. le						MAR 4 1993			A BIRTHR	5:14 5. BIRTHPLACE (State or Foreign		
	096-46-450	83	YRS.	MONTHS	DAYB		RS MIN.		(Month, Day, Year) JUL 8 1909		Country)	Country)		
	9a. FACILITY NAME (# not i		street and number)	0.3		9b. CITY,	TOWN	OR LOCATION	OF DEAT		8 15	V	NTY OF DE	IRGINIA
E I	32.000MT 07.00													
DIRECTOR			L CENTE.	_				1				ONTGO	DMERY	
	10a. STATE	10b. COUNT	Υ		10c. CI	TY, TOWN O	R LOCA	TION						10d. INSIDE CITY LIMITS?
	MARYLAND		TGOMERY			POOL	-							YES 2 NO
MA I	10e. STREET AND NUMBER						10	f. ZIP CODE				10g. CIT	IZEN OF WI	IAT COUNTRY?
FUNERAL	19413 WC	OTTON							837				UNITE	ED STATES
5	11. MARITAL STATUS  1 Never Married 2	Married	12. WAS OECEDEN FORCES? 1	YES 2 X	RMED NO			ENDENT OF				or No-	14. RACE - Black,	- American Indian, White, etc.
⋒	3 X Widowed 4 □ Div		IF YES, GIVE W	AR OR DATES		1	YES	2 X NO	Specify:				Specify	
	15. DE	CEDENT'S EDU	CATION	16e, D	ECEDENT'S	S USUAL OC	CUPATION	DN .		165 (6	ND OF BUS	NESS/INI	MISTRY	WHITE
COMPLETED	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5 +)					work done o	luring me	est of working		100.10		, , , , , , , , , , , , , , , , , , ,	2001111	
립	8		LOMEN	AAVED										
<u>S</u>	17. FATHER'S NAME (First, A		HOMEMAKER  18. MOTHER'S NAME (First, Middle, Maiden Surname)											
BEC	HENRY	UPSHI	RE MAHONE						MADI	ELINE	TOT	ΓEN		
	19a, INFORMANT'S NAME (	Type/Print)		15	b. MAILIN	G ADDRESS	(Street a	and Number or					Code)	
2	ANN CHAMBER	S			10/1	3 140	$\Omega$ TT $C$	N AVE	MILE	POOI	ESVI	TTE	MD	20837
	20a. METHOD OF DISPOSIT	TION		20b. PLACE	AND DATE	OF DISPOS	ITION (N	ame of	WILLIA,	DATE			City or Tow	
	4 Donation 5 Othe		Bric	ck Church cemetery   3/8 Montgomery, N.Y.								N.Y.		
j.	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 21. NAME AND ADDRESS OF FACILITY									1-		-0	- 0 )	
8	►Will -	. C 1	til			D	100	Box 86	rai	Home		25.2	000	
	23. PART I. Enter the	diseases or	complications that	t caused the d	anth Do		the me	do at date	שמע	rnesv.	TTTE	, ma	208	Approximata
RTIFICATION	disease or condition resulting in death)  a. MULTI SYSTEM FAILURE  DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):													
RTIFIC	CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):													
뜅	DART II Other signific	ant consider		4							_			
MEDICAL	PART II. Other signific	ant contation	is contributing to	deeth but not	resulting	in the un	derlyin	g cause giv	ven in Pi		e. WAS AN PERFOR	MED?		WERE AUTOPSY FINDIN WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
A I	25. WAS CASE REFERRED	D MEDICAL												
PHYSICIAN:	EXAMINER?	O MEDICIE	HOSPITAL:		26. PLACE OF DEATH (Check only one) OTHER:									
¥ I	27. MANNER OF DEATH		1 Inpatient 2 28a. DATE OF		28b. TIR		ing Horr	10 5 Reak					011050	
		Pending	(Month, De			JURY	WC	PRK?		8d. DESCR	BE HOW II	NJURY OC	COMED	
B	2 Accident 3 Suicide	Investigation	28a. PLACE OF	F INJURY At h	ome farm	street facts			_	28f. LOCATION (Street and Number or Rural Route Number.				
	4 Homicide	Could not be determined	building,	etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,		, o		1		own, State)	ina namber	or norm no	ole Nonoe,
COMPLET			ICIAN: To the best of ER: On the besis of an											and manner as state
	SHE HIGHATURE AND TITLE				_	_	_	29c. LICENS						Month, Day, Year)
# I	[ human 1]	hu	VE N	20				man	3925					
위	SE HASE AND ADDRESS O	F PERSON WH			M 27) (Type	s, Print)				_	7 A T 3 4	-	493	
			LT, MC.							L NAV			AL CE	NIEK
ľ	31. DATE FILED (Month, Day,	Year)	32. REGISTRA	R'S SIGNATURE				DE1	HEOD	A FID	2000	<u>0-70</u>	VV	
	MAR ()	8 199	3 Julia D	airidan R	inde 82									



	1. DECEDENT'S NAME (First, Middle, Las	MARTE		ITH		F DEATH	2. DATE OF MONTH	DAY	YEAR	3. TIME OF DEATH 21:30 DA		
	4. SOCIAL SECURITY NUMBER 1220-16-1158	5. SEX 1  M 2  TF	6. AGE (In yrs. last	birthday)	IF UNDER 1 YEA		March  7. DATE OF (Month, D) May 3(		B. BIRTHE	21:30 pa PLACE (States or Foreign Vland		
TOR	90. FACILITY NAME (If not institution, give Washington County	street and number)			Hagers	WN OR LOCATION O		9c. Ct	OUNTY OF DE			
DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE  10b. COUN  Maryland Fred	derick			TOWN OR LO					10d. INSIDE CITY LIMITS? 1 YES 2 1 NO		
FUNERAL	100. STREET AND NUMBER 14732 FOXVIIIe-De	eerfield E	Rd.			101. ZIP CODE 21780				HAT COUNTRY?		
BY FUR	11. MARITAL STATUS  1 Never Married 2 Married  3 X Widowed 4 Divorced	12. WAS DECEOEN FORCES? 1 IF YES, GIVE W	T EVER IN U.S. ARI YES 2 RM AR OR DATES	MED O	If yes	DECENDENT OF HIS, specify Cuben, Me YES 2 X NO S	SPANIC ORIGIN? (S exican, Puerto Rica decily:	Specify Yes or No- n, etc.)	14. RACE Black, Specify White			
COMPLETED	15. DECEDENT'S ET (Specify only highest gra Elementary/Secondary (0-12)		(Gi	CEDENT'S US We kind of wo Do NOT use	retired.)	ATION most of working		no of Business/	INDUSTRY			
	17. FATHER'S NAME (First, Middle, Last) Albert	IV/A		Lew		18. MOTHER'S	NAME (First, Midd	lle, Meiden Surneme	9)	Smith		
TO BE	190. INFORMANT'S NAME (Type/Print) Albert L. Smith	(Son)		MAILING A	DORESS (Stre	et and Number or R	ural Route Number,	City or Town, State,	Zip Code)	le, MD 2178		
	20e. METHOD OF DISPOSITION 1 M Burlal 2 Cremation 3 Re 4 Donation 5 Other (Specify)		20b. PLACE A	ND DATE OF	DISPOSITION or place)	DATE 20c. LOCATION — City or Town, Star						
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE		_	Robe:	rt E. Da E. Main	iley & S			omes, P.A. 788		
	iMMEDIATE CAUSE (Finei disease or condition resulting in death)	a. 9AS	TRO, 4 +c	UENCE OF):	el,	henor			arreat,	Approximate Interval Between Onset and Death		
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST  b. ESPHALIS VARICES  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):											
MEDICAL	PART II. Other aignificent conditions of the con	ona contributing to			the underly			e. WAS AN AUTOPS PERFORMED?  YES 2 1 NO		WERE AUTOPSY FINDINGS AMULABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES2 / NO		
AN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO	HOSPITAL:	ER/Outpatient 3		THER:	N. PLACE OF DEATH		Decified .				
BY PHYSICI	27. MANNER OF DEATH  1 Netural 5 Pending 2 Accident Investigation	28s. DATE OF (Month, D	INJURY	28b. TIME (	OF 28c.	INJURY AT WORK?	28d. OESCRI	BE HOW INJURY	OCCURED			
ETED	3 Suicide Could not b. 4 Homicide determined	28e. PLACE O building,	F INJURY — At hor etc. (Specify)	ne, fárm, str	eet, factory, o	office	281. LOCATIO	ON (Street and Num. own, State)	ber or Rural Ro	oute Number,		
141	298. CERTIFIER (Check only one)  1 CERTIFYING PHY one)  2 MEDICAL EXAMI	SICIAN: To the best of NER: On the basis of ex								and manner as etetod.		
TO BE COM	29b. SIGNATURE AND TITLE OF CERTIFICATION OF CERTIFICATIO	12	Las.	we	10	29c. LICENSE	NUMBER 222	29d. D	3 - 4	Month, Day, Year)		
	31. DATE FILED (Month, Day, Year)	Shing to	R'S SIGNATURE	27) (Type, P	1 /h	50.	Hagers	Town	MO	21740		
	3-4-9MAR	1 ( 1993	Julia Da	rdson-1	Pandelle							

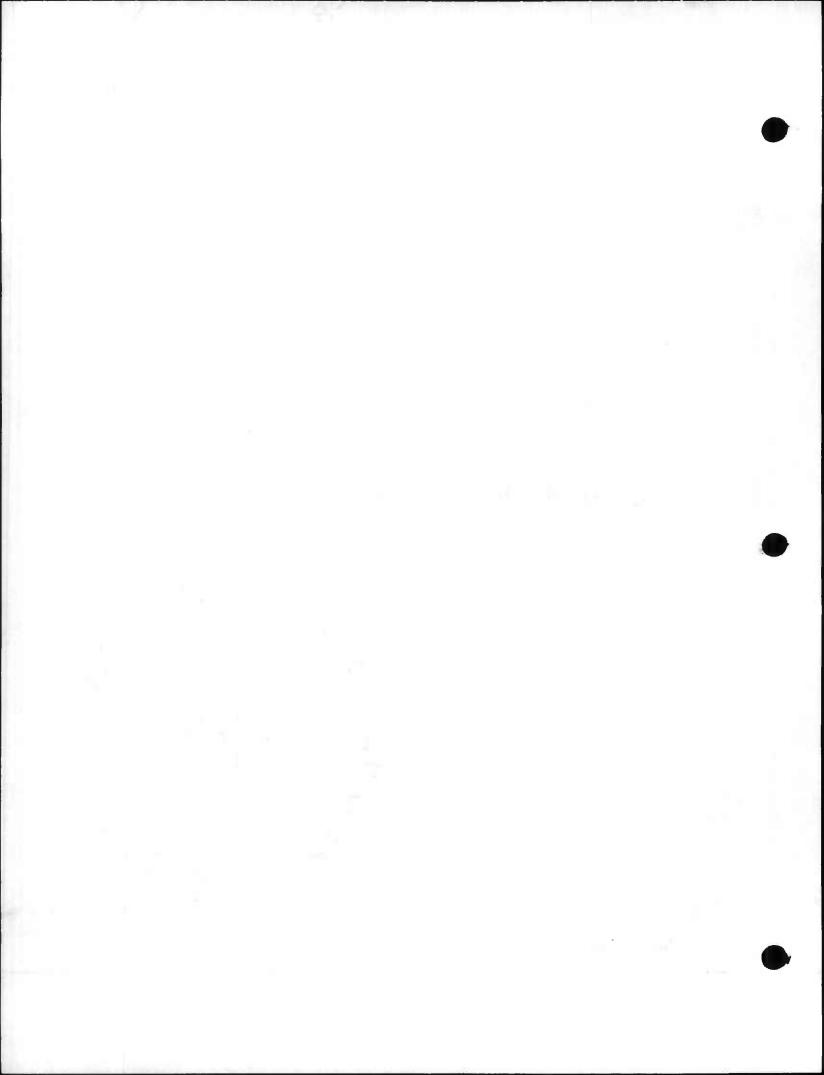


	1. DECEDENT'S NAME (First, Middle, Last)  Banbara McCann Sullivan  Banbara McCann Sullivan  2. DATE OF BEATH  MONTH  3 - 24 - 93										TIME OF DEATH
3	4. SOCIAL SECURITY NUMBER 214-44-0997  9a. FACILITY NAME: THE SECURITY	1 🗆 M 2 🏲 F	8. AGE (In yrs. let		IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.		MATE OF BIRTH Month, Day, Year)	-45	Maj	ryland
DIRECTOR	1004 Sould South Bel air Harfard										
		rford			Air	ATION			Leave or a		10d. INSIDE CITY LIMITS? 1 YES 2 X NO
FUNERAL	1004 Gorsuch		EVER WILL A			21014			US	A	HAT COUNTRY?
B	1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT FORCES? 1 [ IF YES, GIVE WA	YES 2 24	NO .	If yes,	ECENDENT OF HISP, specify Cuban, Maxie ES 2 NO Spec	can, Pu	RIGIN? (Specify Yearto Ricen, etc.)	n or No—	Black, Specify.	- American Indian, White, atc. hite
APLETED	Elementary/Second viriny regiment grater completed) (Sine kind of work done during most of working life. De NOT use retigred) all and the De NOT use retigred) and the De NOT use retigred to the De									ol	
I at once.	17. FATHER'S NAME (First, Middle, Lest) John Mauri	ann			18. MOTHER'S N	othy	irst, Middle, Meiden Virg	şurname) inia	Bro	own	
TO BI	19a. INFORMANT'S NAME (Type:/Print) C. John Sullivan, Jr.  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1004 Gorsuch Garth, Bel Air, Md. 21014										
E E	20a. METHOD OF DISPOSITION X Burlei 2 Cremetton 3 Rei 4 Donation 5 Other (Specify)		20b. PLACE comptery, cre Liltu	and date of the Teach		iends Cer	mete	ery 3-26	-93		n, Stata 1ston, M
examine	21. SIGNATURE OF FUNERAL SERVICE L	McCor	nes	111.	Howa:	and address of i rd K. Mc Cokesbu	Com	as III F			
me meanca	that initiated events  resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):									Approximate Interval Bety	
FETTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	b DUE TO (C	OR AS A CONSE	OUENCE OF	):  :	letaji	en	ltan			Onset and E
MEDICAL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	b	OR AS A CONSE	OUENCE OF	:				RMED?	6	VERE AUTOPSV FINDINALABLE PRIOR TO COMPLETION OF CAU
MEDICAL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST	b	OR AS A CONSE	OUENCE OF	the underlyi	ing ceuse given in	n Part	i. 24a. WAS AN PERFOI 1  YES 2	RMED?	6	VERE AUTOPSY FIND WALLABLE PRIOR OF CAU OF DEATH?
PHYSICIAN: MEDICAL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST  PART ii. Other significent condition  PART ii. Other significent c	b. DUE TO (O d. DUE TO (O d. MARKETTE & D. MARKETTE & DUE TO (O d. MARKETTE & D. MARKETTE & DUE TO (O d. MARKETTE & D. MARKETTE & D. MARKETTE & DUE TO (O d. MARKETTE & D. MARKETT	OR AS A CONSE	OUENCE OF	26. OTHER: 4   Nursing Ho OF   28c.	ing ceuse given in	n Part	i. 24a. WAS AN PERFOI 1 VES 2	RMED?	6	VERE AUTOPSY FIND MAILABLE PRIOR TO COMPLETION OF CAU OF DEATH?
BY PHYSICIAN: MEDICAL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST  PART if. Other significent condition  PART if. Other significent conditions  PART if. Other significant conditions  PART if. Other significant conditions  PART if. Other significent conditions  PART if. Other significant c	b. DUE TO (C) c. DUE TO (C) d	OR AS A CONSE	OUENCE OF	26. OTHER: 4   Nursing Ho OF 28c. W	PLACE OF OEATH (Come 54) Residence	n Part	i. 24a. WAS AN PERFOR 1 VES 2	NJURY OCCI	UREO	WERE AUTOPSY FIND MALLABLE PRIOR TO COMPLETION OF CAU OF DEATH?  2 YES 2 NO
LETED BY PHYSICIAN: MEDICAL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST  PART ii. Other significent condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined  29a. CERTIFIER (Check only one) 2 MEDICAL EXAMIN	b. DUE TO (C) c. DUE TO (C) d	OR AS A CONSE	OUENCE OF	26. OTHER: 4   Nursing Ho OF 28c. IP M 1 reet, factory, off	PLACE OF OEATH (Come 5 Residence NJUNY AT OVERY 2 NO	n Part	i. 24a. WAS AN PERFORM  1 YES 2  Other (Specify)  OESCRIBE HOW I  LOCATION (Street City or Town, State)	NJURY OCCL	UREO  Or Bural Root  d.	WERE AUTOPSY FIND WERE AUTOPSY
TED BY PHYSICIAN: MEDICAL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST  PART II. Other significent condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5 Pending Investigation  3 Suicide 6 Could not be determined  29a. CERTIFIER (Check only one)  29b. SIGNATURE AND TITLE OF CERTIFIER  29b. SIGNATURE AND TITLE OF CERTIFIER	b. DUE TO (C) c. DUE TO (C) d	OR AS A CONSE	OUENCE OF OUENCE OUENCE OUENCE OF OUENCE OUENC	26. OTHER: 4   Nursing Ho OF 28c. IP M 1 reet, factory, off	PLACE OF OEATH (COME of Residence NUMBER of NO	n Part	i. 24a. WAS AN PERFORM  1 YES 2  Other (Specify)  OESCRIBE HOW I  LOCATION (Street City or Town, State)	NJURY Occu	UREO  d.  cause(a) a	WERE AUTOPSY FIND WERE AUTOPSY

21215-0020	ld or attending physician.	for use as the burial-transit permit.
BALTIMORE, MARYLAND 21215-0020	ry be retained by the hospital	page 5 should be detached
BALTIMOR	hours after death. Page 6 ma	ed in by the funeral director, p
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	L. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	L DIRECTOR: After this centificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.
DIVISION OF VITAL R	L OR ATTENDING PHYSICIAN: The law n	DIRECTOR: After this certificate has be

DING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	I-transit permi	be filed within 72 hours after death with the State Dept. or Health and Mental Hygiene prior to bun'al, cremation, or removal.	
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law rec	is beer	ept. of	92 ch
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TO THE HOSPITAL OR ATTENDING PHYS	NERAL	hin 72	WT. 16
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9	10	be fi	Q PI

_	1 - STATE REGISTRAR	SIAIE UF	MAKYLAND /				TEALTH DEAT		MENTAI	REG. NO			
1	1. DECEDENT'S NAME (First, Middle,	JAMES	Ε.		S	Lo	تما يخ	4	MONTI		AY 10	YEAR 193	3. TIME OF OEATH  /334 M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	st birthday)	IF UNDER	YEAR	IF UNDER	24 HRS	MAR	OF BIRTH	7 1		PLACE (State or Foreign
1 1	214-28-3481	1 G/M 2 🗆 F	62	YRS.	MONTHS	DAYS					Country)		
	Sa. FACILITY NAME (If not institution,	give street and number)			9b. CITY	TOWN (	OR LOCATIO	ON OF DEA		19-1		NTY OF DE	
TOR	PENINSULA REGI	AL CENTE	R	5	SALI	SBURY	7				COMI		
DIRECTOR	10a. STATE 10b. CC			10c. CIT	TY, TOWN C	LM A 1		_	_			T	10d. INSIDE CITY LIMITS?
1	10s. STREET AND NUMBER	VICONICO			DEI		. ZIP CODE						1 - YES 2 - NO
FUNERAL	RT.#3,222A	ROAD			100	218				10g. CITI		A .	
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	NT, EVER IN U.S. AR 14 YES 2 1 WAR OR DATES U . S . A R I	NO		If yes, sp	ENDENT O	n, Mexican	n, Puerto I	? (Specify Yestican, etc.)	s or No	14. RACE	- American Indian, White, etc.	
ED	15. DECEDENT'S	EDUCATION	16a. DE	CEDENT'S	USUAL O	CCUPATIO	DN .		16b.	KIND OF BU	SINESS/IND	USTRY	WHILE
COMPLET	(Specify only highest Elementary/Secondary (0-12)	College (1-4 or 5	)+)			during mo	ast of workin	g					
N N	1.2 17. FATHER'S NAME (First, Middle, Las	4)	V	ENDE	R		18. MOTH	IFR'S MAN	AF (First A	VEND		<u>co.</u>	
l w l	GEORGE A.	STEWART								F. C1			
10 B	19a. INFORMANT'S NAME (Type/Print) PAT STEWAR		19				and Number	or Rural R	loute Numb	oer, City or Tow	m, State, Zip		
	20a. METHOD OF DISPOSITION	-	20b. PLACE				_	ARIU	DATI		DELI CATION -		MD. 21875
1	1 Surial 2 Commetten 3 4 Donatton 9 Other (Specify)		cemetery, cre	matery or o	other place)			FRV	-1	2 SAI			
	21. SIGNATURE OF FUNERAL SERVICE	E LICENSEE	0	- 414	22.	NAME A	NO ADDRES	S OF FAC	HLITY	ZIDAI	11351	JAL	
	Duald ( Sound Bounds funeral Home, Salisbury, MD.												
	23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ehock, or heert feliure. Liet only one cause on eech line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Approximata interval Between Onset and Death  Oue To (or as a consequence of):  Candid any of the conditions.												
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  CONCLU OMMON 'G.  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):												
MEDICAL	PART II. Other eignificant cond	fitions contributing to	tis.	resulting	in the un	derlying	g cause g	iven in F	Part i.	24a. WAS AN PERFOR	RMED?		WERE AUTOPSY FINDINGS MARILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDIC. EXAMINER?	HOSPITAL:					ACE OF D	EATH (Chec	ck only on	e)			
YSI	1 TES 2 NO	1 hpatient 2	☐ ER/Outpatient 3	□ DOA	OTHER 4 - Num		e 5 □ Re	sidence (	6 🗆 Other	(Specify)			
	27. MANNER OF DEATH Natural 5 Pending		F INJURY Day, Year)	28b. TIN	HE OF JURY M		URY AT		28d. DE\$	CRIBE HOW I	NJURY OCC	CURED	
TED BY	2 Accident Investigat 3 Suicide 8 Could no 4 Homicide determine	28e. PLACE (	OF INJURY — At he i, atc. (Spec/ly)	ome, ferm,	street, fact			-	28f. LOCA	ATION (Street or Town, State)	and Number	or Rural Ro	oute Number,
COMPLETE		PHYSICIAN: To the best of											and menner ee stated.
TO BE C	29b. SIGNATURE AND TITLE OF CERT	belly.	$M \cdot D$ .				29c, LICE D2	NSE NUM	BER 36	10	29d, DATE ▶ 3	SIGNED	Month, Day, Year)
F	30. NAME AND ADDRESS OF PERSON	9 6 4	SE OF DEATH (ITE	M 27) (Type	Print) S	no	1. gr	mív(	2 1	SALI	JBU	Ry.	M.D. 3181.
6	31 MAR 1 1 1993"	July Davidso	AR'S SIGNATURE										



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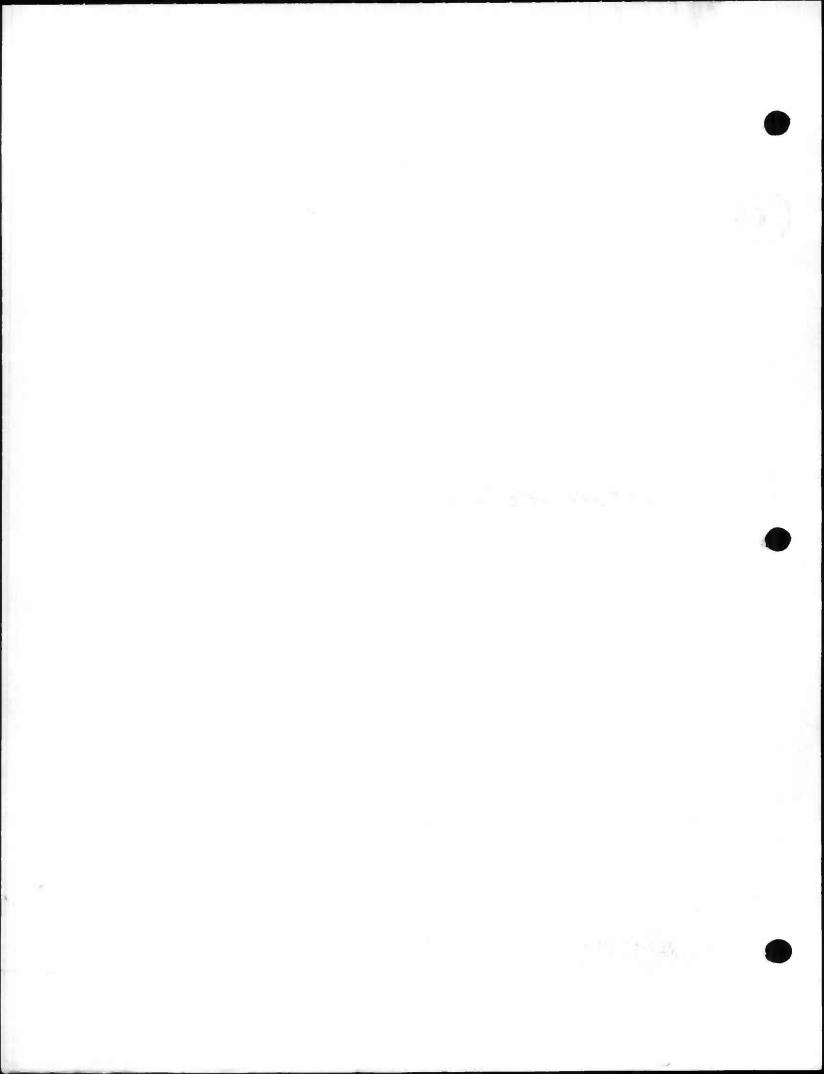
BALTIMORE, MARYLAND 21215-0020

TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transi be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Nem 28 is marked, or Nem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	HEGISTHAH			ERIIF	ICALI	EUF	DEAT	Н	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)	-1							2. DATE OF DEATH	ıv	VEAD	3. TIME OF DEATH	
	Emil S								монти 03 1	O	93	1:16Pm	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. la:	st birthday)	IF UNDER		IF UNDER 2		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTH	IPLACE (State or Foreign	
	170-12-8384	1  M 2  F	78	YRS.	MONTHS	The state of the s						nnsylvania	
	9e. FACILITY NAME (If not institution, give s.				9b. CITY	, TOWN C	R LOCATION	N OF DE		_	NTY OF D		
e l	Wicomic			Sal	isbur	v		Wi	comi	00			
5	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY 10b. COUNTY										50		
DIRECTOR	IDE. CITY, TOWN OR LOCATION 10d										10d. INSIDE CITY LIMITS?		
												YES 2 NO	
FUNERAL				10f	ZIP CODE			10g. CITI	ZEN OF V	VHAT COUNTRY?			
R	1406 Emerson Ave			_	21801			US	SA				
크	11. MARITAL STATUS  1 Never Married 2 Merried	MARITAL STATUS  12. WAS DECEDENT EVER IN U.S. AR FORCES? 1 YES 2 N					ENDENT OF	HISPANI	C ORIGIN? (Specify Yes, Puerto Rican, etc.)	or No-	14. RACE	- American indian, t, White, etc.	
BY	3 2 Widowed 4 Divorced	Coast (					2 🔯 NO				Speci		
	15. DECEDENT'S EDUC			CEDENT'S	1101141 0				т			hite	
E	(Specify only highest grade	completed)	(G	ive kind of v	vork done	during mo	st of working		16b. KIND OF BUS	SINESS/ING	USTRY		
PL	Elementary/Secondary (0-12)	College (1-4 or 5 +	, ,	lraft									
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)												
	Elmer (unk) Scho	tt					Te. MOTHE	Ann Can	ie (First, Middle, Maiden	Surname)	n		
BE	19e. INFORMANT'S NAME (Type/Print)		40										
2	Charles R. Dashi	ell Ir	la la						oute Number, City or Town				
1	20a. METHOD OF DISPOSITION	011 011	20b. PLACE					-					
	1 Burlel 2 Cremation 3 Remo	oval from State	cemetery, cre	matory or of	her plece)							ry, MD	
,	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE /	Jair	sbur			D ADORESS	OF FACI		alls	bury	, FID	
· ·	· Auton	1601	2 _						uneral Hor	ne			
	900/11.		way			50	1 Snc	w H	ill Rd., S	Salis	bury	, Md. 21801	
1	23. PART I. Enter the diseases, or coshock, or haert feiture. I	omplications that list only one cau	caused the de	ath. Do n	ot enter	the mod	de of dying	g, such	as cardiac or respi	ratory arr	eat,	Approximete	
1	IMMEDIATE CAUSE (Final		0	"								Interval Between Onset and Death	
1	diseese or condition reaulting in death)	Ma.	assive (	astr	osto	my E	leed,	et:	iology unk	mown			
	OUE TO (OR AS A CONSEQUENCE OF):												
Z	Sequentially list conditions, ASCVD, advanced and diffused												
Ĕ	if any, leading to immediate cause. Enter UNDERLYING	DUE TO	OR AS A CONSEC	DUENCE OF	):								
일	CAUSE (Diseese or injury	Ce	rebral	Vasc	ular	Acc	ident	,					
	thet initiated eventa reaulting in deeth) LAST	DOE 10 (	OR AS A CONSEC	DUENCE OF	):								
CERTIFICATION								_					
4	PART ii. Other aignificent conditions	contributing to	deeth but not r	esuiting i	n the un	derlying	cause giv	en in P	ert I. 24s. WAS AN		24b.	WERE AUTOPSY FINOINGS	
EDICAL									PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE	
									1 TYES 2	X NO		OF DEATH?	
×									-			1 YES 2 NO	
¥	25. WAS CASE REFERRED TO MEDICAL					26. PL	ACE OF DEA	TH (Chec	k only one)				
PHYSICIAN:	EXAMINER?	HOSPITAL:	ER/Outpatient 3	DOA	OTHER AL Num	1:			Other (Specify)				
È	27. MANNER OF DEATH	28e, DATE OF	NJURY	26b. TIME	OF	28c. INJL		_	28d. OEŞCRIBE HOW IN	LIURY OCC	UREO		
	1 Natural 5 Pending	(Month, Da	y, Year)	INJ	JRY M	WOR	RK? ES 2 - P	- 1			OILL		
BY	2 Accident Investigation 3 Suicida & Could not be	28e. PLACE OF	INJURY — At ho	me, farm, s	treat, facto			$\rightarrow$	201. LOCATION (Street or	nd Number	or Rural B	oute Mumber	
밀	4 Homicide determined	building, e	rtc. (Specify)						City or Town, State)		0. 110.0.11	To trained,	
COMPLET	29a, CERTIFIER 1 CERTIFYING PHYSIC	NAM: To the best of a	ny kaomina na sa	ave III.									
\$	(Check only one) 2 MEOICAL EXAMINER	t: On the besis of ex	my knowledge, de emination and/or i	mmetication	d at the ti	me, dete	end piece, er	nd due to	the ceuse(e) end men	ner as atate	id,		
11	29b. SIGNATURE AND TITLE OF CERTIFIER				1, 111 my 0	piritori, de				due to the	ceuse(e)	end manner ee stated.	
8	/_	7700	27	ms		- 1	29c. LICENS		ER	29d. DATE	SIGNEO	(Month, Day, Year)	
o IL	30. NAME AND ADDRESS OF PERSON WHO						D020	026	-		03/1	1/93	
,	Federico G.	AL'UNES,	MD TOS	∠ A C	cear	Pir	nes, I	Berl	in, Md. 2	1811			
4	MAR 1 2 1993	2 32. REGISTRAF	n-Mandel										
	111111111111111111111111111111111111111		•										

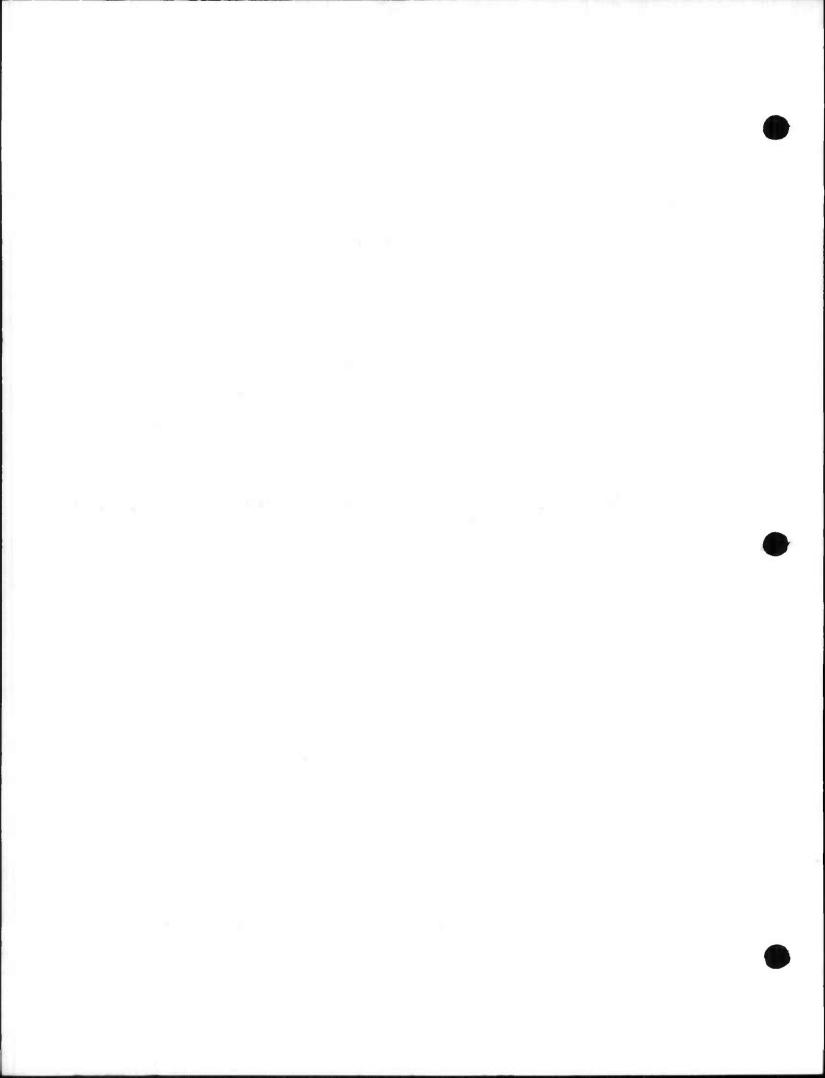


		1. DECEDENT'S NAME (First, Middle, Last)			• .					2. DATE OF O	DEATH	, y	EAR 3.	TIME OF DEATH
		4. SOCIAL SECURITY NUMBER	(ecil	O <sub>I</sub>	n/#	7				03	0	8 9.	3/	1-142 PM
	1	406-14-6467	5. SEX	6. AGE (In yrs. les	YRS.	IF UNDER	DAYS	HOURS	24 HRS.	7. DATE OF E	y, Ybar)		Country)	ACE (State or Foreign
pinous		9a. FACILITY NAME (If not institution, give		0/		9b. CITY,	TOWN	OR LOCATIO	ON OF DEA	Septo	4, 1	9c, COUNTY		ressee
	DIRECTOR	Meridian Nursin	g Home			_		stow					imon	
19 E	35	10a. STATE 10b. COUNT	γ		10c. CITY	Y, TOWN O	LOCA	TION					10	d. INSIDE CITY
ji.		Maryland Bal	timore		Ro	undal	-	_					1,	YES 2 NO
physician. burial-transit permit.	FUNERAL	1119 Liberty Roa	d					2//3				10g. CITIZER	S A	T COUNTRY?
physician. burial-trar	I S	11. MARITAL STATUS	12. WAS DECEDENT FORCES? 1	T EVER IN U.S. AR	MED		AS DEC	CENDENT O	F HISPANI	IC ORIGIN? (S		or No — 14	RACE -	American Indian, /hite, stc.
attending ph se as the bu	BY	1 Never Married 2 Married 3 Widowed 4 Divorced	WW //	YES 2 1		1	_ YES	8 2 NO	Specify:		i, atc.)		Specify:	White
or atte	E	15. DECEDENT'S EDI (Specify only highest grad		(G	CEDENT'S	vork done di	CUPATION TO COMPANY	ON ost of workin	g	16b. KIN	D OF BUSI	NESS/INDUS	TRY	
pital ed fo	COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 +	)	ad Ma		nan	ce		Anı	ne An	undel	Cou	nty
	00	17. FATHER'S NAME (First, Middle, Last)	,					1 .		AE (First, Middle		Surname)		
uld be		Webster Smit	r	- Lon						e Sp				
5 should notified	5	Susie Tarr		19/		-		e Dri		China			de)	
nay be page				20b.PLACE	AND DATE O	FDISPOSI	_		ve,	(hince		ATION - CITY	or Town	NLQ 23330
executed within 24 hours after death, Page 6 may be and completely filled in by the funeral director, page 0 burial, cremation, or removal.  natic event, the medical examiner must be it		20e, METHOD OF DISPOSITION  1 Burial 2 Cremation 3 Ren 4 Donation 5 Other (Specify)		- Cemetary, cre		emet	-				01	Hall,	Vir	ginia
death. Pag funeral dii l. examiner		21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	1	1	22 N	AME AL	ND ADDRES	S OF FAC	L'Home	2			
ter dea the fur oval.	Щ	Constance	delyn	Gord	-	$\Box G$	rine	cotea	que.	Virgi	nia.	23336		
d in by the or removal medical		23. PART I. Enter the diseases, or shock, or heart failure.	complications that List only one cau	t ceused the de se on each line	eth. Do n	ot enter t	he mo	oda of dyl	ng, auch	as cardiec	or reapin	etory arreat	t,	Approximata Interval Between
24 hour filled tion, or the m		IMMEDIATE CAUSE (Finel disease or condition	A	to	M	100		Ji.	1	Int		. / ,		Onset and Death
ted within 24 completely fill ial, cremation, event, the		resulting in death)	DUE TO	(OR AS A CONSEC			000	1 100		chart	8, C	101	7	-
and con burial,	Z	Secure that we did an	b											ļ
or to	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO	(OR AS A CONSEC	QUENCE OF	):								
a de de	틸	CAUSE (Disease or Injury that initiated events	DUE TO	(OR AS A CONSEC	DUENCE OF	):								
attending ntal Hygier Y, or oth	開	resulting in death) LAST	d											
		PART II. Other aignificant condition	ns contributing to	daath but not r	eaulting is	n the und	erlyin	g cause g	iven in P	Part I. 24a	. WAS AN A		24b. WE	RE AUTOPSY FINDINGS
uires that the signed by Health and Iws any In	DICAL									_   1	PERFORM		CC	AILABLE PRIOR TO PMPLETION OF CAUSE DEATH?
en sign of Hea	M													YES 2 NO
has been Dept. of	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL												
rSician: The law certificate has I the State Dept d, or Item 23	SICI	EXAMINER?	HOSPITAL:	ER/Outpetient 3	□ DOA	OTHER		LACE OF O						
YSICIA s certif th the od, or	μŽ	27. MANNER OF DEATH	26a. DATE OF (Month, De	INJURY	26b. TIME	OF :	8c. INJ	JURY AT		28d. OESCRIE		JURY OCCUR	EO	
NG PHYS fter this c eath with marked,	BY	1 Natural 5 Pending 2 Accident Investigation	(month, De	iy. rear)	INJU	M		YES 2	NO					
TTENDI TOR: A after de 28 Is	8	3 Suicide 6 Could not be 4 Hemicide determined	28a. PLACE Of building,	F INJURY Al ho atc. (Specify)	me, farm, si	treet, factor	y, offic	ea .		26f. LOCATION	N (Street en wn, State)	d Number or i	Rural Rout	e Number,
DIRECT HOURS	PLE	29e. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best of	my knowledge, de	ath occurre	d at the lin	ne, data	and place,	and due to	o the cause(a)	and mann	er sa stated.		
HOSPITAL FUNERAL WITHIN 72 TANT: If	COMPLET	one) 2 MEDICAL EXAMINI	ER: On the beels of ex										euse(a) an	d manner as stated.
TO THE HOSPI TO THE FUNER DE filed within IMPORTANT:	O BE	296. SIGNATURE AND TITLE OF CERTIFIE  TENOME	100 m	153 EN	5,1	nil	?	29c, LICE	NSE NUME	096	4	29d. DATE SI	GNED (MG	onth, Day, Year)
		30. NAME AND ADDRESS OF PERSON W	O COMPLETED CAUS	E OF OEATH (ITE	127) (Type,	Print)	8	630		135	ery	PLA	24	MALL
	3	31. DATE FILED (Month, Day, Year)		R'S SIGNATURE				-7"	2/1	45/	J. V.	1 /11	9	21123
)	WA	MAR 1 6 1993	Julia Davids	on-Alandel	ک									

9 ... 

DHMH-16 Rev 1/89

		* REGISTRAR		CERTIF	ICATE OF	DEATH		REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last)						OF DEATH		3.	TIME OF DEATH
		Irene Francis S	Serman				03/		93	EAR	5:00 AM
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		OF BIRTH			ACE (State or Foreign
		218-20-6133		78 YRS.	MONTHS DAYS	HOURS MIN.	(Monti	, Day, Year)		Country)	
A STATE OF THE PARTY OF THE PAR		9a. FACILITY NAME (If not institution, give a		70	31 COTY TOWN	-2.1.534TION OF D	01	/ 22/		Mary	
3	ac	The state of the s		0.7		OR LOCATION OF D	EATH		9c. COUNTY		
N)	1 2	Walston Switch T	railer rk.,	C-/	Salis	bury			WI	comi	20
	DIRECTOR	10a. STATE 10b. COUNT	Υ	10c CIT	Y, TOWN OR LOCA	TION				1.0	· Claime arey
age of	<u>۳</u>		comico		lisbury						d. INSIDE CITY LIMITS?
permit.		10e. STREET AND NUMBER	OlliTCO	U a							YES 2 NO
	A A				- 1	M. ZIP CODE					T COUNTRY?
in. Tansi	l iii	Walston Switch Tr				21801			U:	SA	
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit ontified at once.	FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER FORCES? 1 YES	IN U.S. ARMED	13. WAS DE	CENDENT OF HISPA	NIC ORIGIN	? (Specify Yea	or No- 14	RACE -	American Indian,
215-0020 attending physic	ВУ Б	1 Never Married 2 Married  3 Wildowed 4 Divorced	IF YES, GIVE WAR OR I			pecify Cuban, Maxico S 2 NO Speci		Rican, atc.)		Black, W Specify:	Trita, atc.
5-0 anding		3& widowed 4   Divorced								whit	e
121		15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S	USUAL OCCUPAT	ION	16b.	KIND OF BUS	INESS/INDUS	TRY	
21 alor for u	[	Elamentary/Secondary (0-12)	College (1-4 or 5+)		vork done during m e retired.)						
D spitt	I de	12	71.27	nu	rse aid	e		medi	ical		
AND the hospit detached	COMPLETED	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	AME (First, A	fiddle, Maiden	Sumame)		
MARYLAND retained by the hospit 5 should be detached motified at once		Roland (unk) Pra	ag					Rial			
Ould ould	B	19a. INFORMANT'S NAME (Type/Print)		10h MAII NO	ADDRESS (Charles	and Number or Rural					
MARYL retained by 5 should be	ဥ									de)	
		Roland E. Serman				247A, D	over,	DE I:			
BALTIMORE, after death. Page 6 may be by the funeral director, page monoval.		20a. METHOD OF DISPOSITION  1 1 Burlal 2 Cremation 3 Rem		b. PLACE AND DATE Cometery, crematory or of		ame of	DATI		CATION — City	or Town,	Stata
S e e		4 Donation 5 Other (Specify)		Parsons C			3/1	1 Sa	alisbu	ry,	MD
TI. Pa		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			ND ADDRESS OF FA					
ALTIN death. Pag tuneral di l.		+ Ulban 1	holling	, _		oway Fun					
B fter of the loval.		11- 21/10	weroway		501	Snow Hil	1 Rd.	, Sal:	isbury	, Md	. 21801
DS, P.O. BOX 68760,  The death certificate be executed within 24 hours after the attending physician and completely filled in by the Mental thyghene prior to burial, cremation, or removal niure, or other traumant event, the medical is		23. MART I. Enter the diseases, or a ahock, or heart fallure.	complications that cause List only one cause on o	ed the death. Do n	Dt enter the me	ode of dying, suc	ch aa card	lec or reapl	ratory arrest	,	Approximate interval Between
Filled on one		IMMEDIATE CAUSE (Finel	0-	/	0.	- 4					Onset and Death
tely fille nation,		disease or condition resulting in death)	· Ya	noreste	c car	ch.					Im.
cxecuted within and completely to burial, crema matic event.			DUE TO (OR AS	A CONSEQUENCE OF	7:						1790
87 cuted d con unfal,											
P.O. BOX 68  h certificate be execut  anding physician and c  Hygiene prior to buria	CERTIFICATION	Sequentieily list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE OF	):						
OX e be e sician prior to	Ķ	cause. Enter UNDERLYING									
B. British	프	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS	A CONSEQUENCE OF	):						
O. Gerding	E	resulting in death) LAST									
Beath attended in the Indian			d								
CORDS, res that the deat igned by the att eafth and Menta is any injury.	ارا	PART II. Other aignificant condition	a contributing to deeth i	but not resulting i	n the underlyin	g ceuse given in	Part t.	24s. WAS AN		24b. WE	RE AUTOPSY FINDINGS
ORC that the	EDICAL		nsml					PERFOR		AM	MPLETION OF CAUSE
Sa signe	<u></u>		10010					1 TYES 2	□-¶0		DEATH?
REC requires been sign to differ the sign shows	Σ									1 [	YES 2 AO
law las boopt.	z										
DIVISION OF VITAL RECORDS, P.O. B( OR ATTENDING PHYSICIAN: The law requires that the death certificate DIRECTOR: After this certificate has been signed by the attending physician ster least with the State Dept. of Health and Mental Hygiens pricem 28 is marked, or item 23 shows any injury, or other pr	SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			LACE OF DEATH (Ch	eck only on	)			
VI STAN: or its	S	1 TES 2 AO	1 Inpetient 2 ER/Out	tpatient 3 🗆 DOA	OTHER: 4 Nursing Hon	ne 5 Rasidence	6 Other	(Specify)			
YSICI YSICI S cer th th	1	27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)	28b, TIME	OF 28c, IN.	JURY AT	_		JURY OCCUR	ED	
PH in the sarks	7	1. Natural 5 Pending	(Month, Day, rear)	ил		ORK? YES 2 NO					
LON OF NOING PHYS S: After this of death with is marked,	B		28e. PLACE OF INJURY	Y — At home, term, s			281 1 004	TION (Street a	nd Number or I	Drum I Drumb	Mumbaa
DIVISION OR ATTENDING P DIRECTOR: After t hours after death item 28 is mart	I III	4 Homicide 6 Could not be	building, etc. (Spe	ecify)	areat, rectory, orm	-	City o	or Town, State)	na Number or I	HUNIII HOURE	Number,
DIVISION OR ATTEN DIRECTOR: hours after Item 28 I	<u> </u>	29a. CERTIFIER									
	COMPLET	(Check only	CIAN: To the best of my know								
THE HOSPITAL THE FUNERAL filed within 72 t	ő	2 MEDICAL EXAMINE	R: On the basis of examination	on and/or investigation	n, in my opinion, o	death occured at the	time, deta	and place, and	due to the co	euse(a) an	d manner as stated.
THE HOSPIT THE FUNER filed within	u C	29b. SIGNATURE AND TITLE OF CERTIFUR	A 1	)		29c. LICENSE NUI	MBER		29d DATE SI	ONED /M	onth, Day, Year)
P # 1 1 2 1	8	Soldine .	Lliant	AB. (		P300			▶ 3/	SIVED IMI	Co Co
223	일	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF D	EATH (ITEM 27) (Image	Out-es	700	01)		2	17 (	4)
		Steven L. Craws		560 Rive	rside D	r., Suite	e A-2	06, Sa	lisbu	y, N	1d. 21801
	8	MAR 16 1993	32. REGISTRAR'S SIGN	NATURE							
	1 11	I WAK I K 1930 🔅	Allia Lairdson-V	janaeuc							

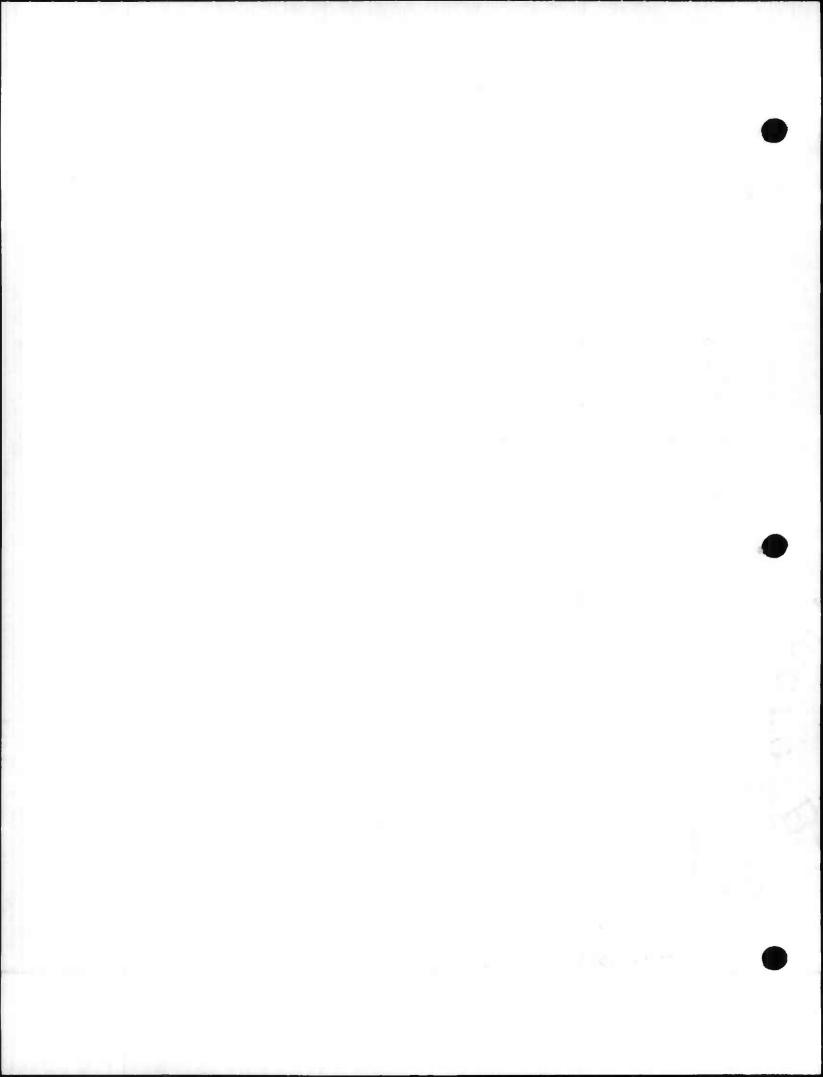


FOR

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCICHE

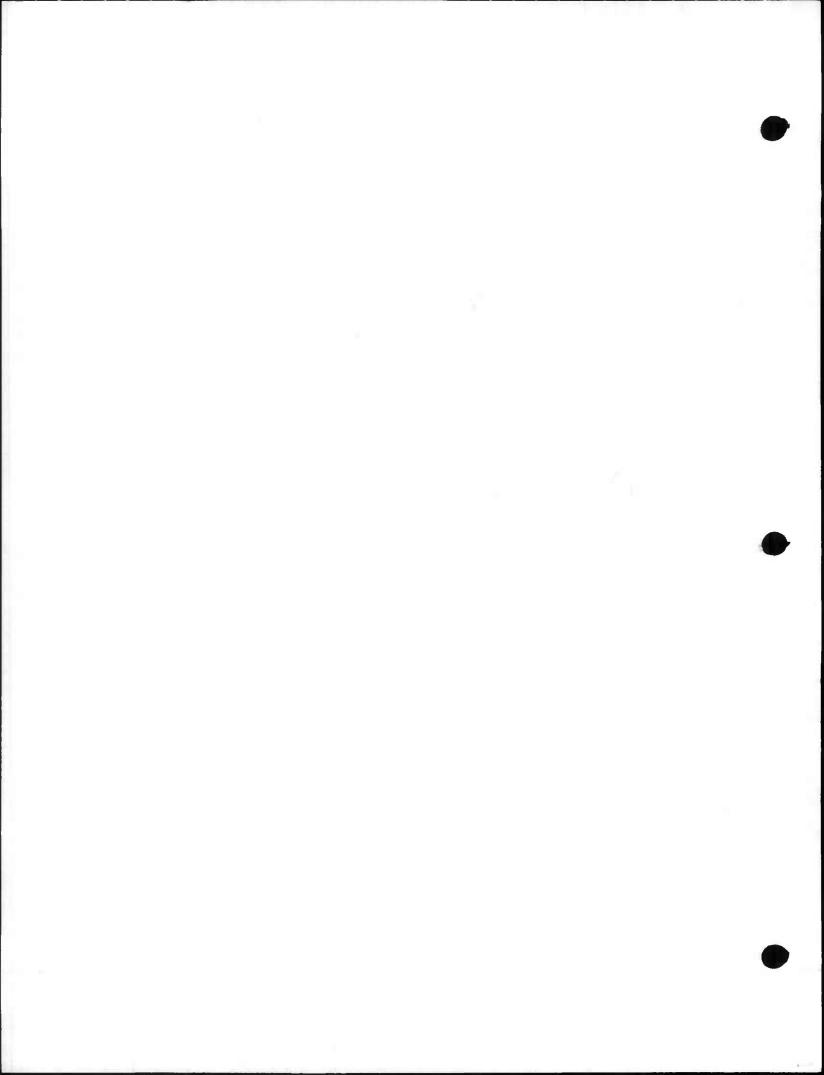
	1 - STATE  CERTIFICATE OF DEATH  REG. NO.								
	1. DECEMPENT'S NAME (First, Middle, Last)  NO DERT No STUDS  2. DATE OF DEATH MONTH DAY SEAR 7/10 PM								
9	4. SOCIAL SECURITY NUMBER 233-48-7104  5. SEX 1 M 2 F  6. AGE (In yrs. lest birthdey) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BIRTTH (Month, Day, Year) WONTHS DAYS HOURS MIN. 2/1/32  WVa.								
TOR	9a. FACILITY NAME (If not institution, give street and number)  9b. CITY, TOWN OR LOCATION OF DEATH  9c. COUNTY OF DEATH  Washington  RESIDENCE OF DECEDENT								
DIRECTOR	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIGE CITY LIMITS?  Md. Washington Hagerstown 1½ YES 2 □ NO								
FUNERAL	100. STREET AND NUMBER  56 Murph Avenue  101. ZIP CODE  21740  USA								
BY FU	11. MARITAL STATUS  12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1. Yes 2 NO IF YES, QIVE WAR OR DATES  13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.)  14. RACE — American Indian, Black, White, etc.  15. YES 2 NO Specify:  16. YES 2 NO Specify:  17. YES 2 NO Specify:  18. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.)  19. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.)  19. YES 2 NO Specify:  10. YES 2 NO Specify:  11. YES 2 NO Specify:  12. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.)								
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5 +)  BLACK  16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  16b. KIND OF BUSINESS/INDUSTRY								
OMP	Flementary Groom Charlestown Race Track  17. FATHER'S NAME (First, Middle, Leat)  18. MOTHER'S NAME (First, Middle, Maiden Surname)								
BE C	Newton Stubbs Mary Williams								
2	190. INFORMANT'S NAME (TyperPrint)  190. MAILING ADDRESS (Street end Number or Flural Route Number, City or Town, State, Zip Code)  Crystal Ann McDaniel  527 Gray Ave.#6, Winchester, Va. 22601								
	20a. METHOD OF DISPOSITION  20b. PLACE AND DATE OF DISPOSITION / Name of OATE  20c. LOCATION — City or Town, State								
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY								
-	Watson Funeral Home  21 W. Bethel St. Hagerstown, Md. 21740  23. PART I. Enter the diseeses, pr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,   Approximate								
	interval Between Onset and Death Onset and Dea								
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING								
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST  DUP TO (OR AS A CONSEQUENCE OF):  The substitute of the substitut								
DICAL (	PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.  24a. WAS AN AUTOPSY PERFORMEO?  AMALABLE PRIOR TO								
PHYSICIAN: MEDI	1 U YES 2 MO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO								
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:								
HYSI	1   YES 2   NO   1   Inpatient 2   ER/Outpetient 3   DOA   4   Nursing Home 5   Residence 8   Other (Specify)    27. MANNEB-0F DEATH   28e. DATE OF INJURY   28b. TIME OF   28c. INJURY AT   28d. DESCRIBE HOW INJURY OCCURED								
ВУ Р	1 Naturel 5 Pending (Month, Day. Year) INJURY WORK? 2 Accident Investigation M 1 YES 2 NO								
	3 Suicide 8 Could not be determined 28. PLACE OF INJURY — Ai home, farm, street, factory, office building, etc. (Specify) 28. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
COMPLETED	29e. CERTIFIER (Check only one)  1 CERTIFIER (Check only one)  2 MEDICAL EXAMINER: On the basic of my knowledge, death occurred at the time, date and place, end due to the cause(e) end manner as stated.								
TO BE	296. SIGNATURE AND TITLE OF CERTIFIER  296. LICENSE NUMBER  29d. DATE SIGNSG (Month, Opty, Year)  3 / 2 / 9 3  30. NAME AND ADDRESS OF PERSON YORD CAUPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)								
	MARTIN W. OMINGHER, JR, ND 324E, ANTIGTAM HAGERSTOWN MD 31. DATE FILEO (MONTH), Day, YOUT) 32. REGISTRAR'S SIGNATURE								
	MAR 22 1993 A								



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	Section 1	nt and the stood	
BALTIMORE, MARYLAND 21215-0020	i hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	e medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the it is filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1	1. DECEDENT'S NAME (First, Middle,	Last)							2. DATE OF DEATH			3. TIME OF DEATH
	E	Beatrice Li	llian S	proul	S					13-	93	9:23 AM
1 1	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I		IF UNDER 1	YEAR	IF UNDER	R 24 HRS.	7. DATE OF BIRTH	.5-		LACE (State or Foreign
g	161-50-1659	1 🗆 M 2 🕢 F	86	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year)	006	Country)	
- 5	Sa. FACILITY NAME (If not institution,	give street and number)	00		9b. CITY	TOWN O	E LOCATI	ON OF DE	5-07-19	-	Penn	sylvania
<b>E</b>												
읝	Reeders Memor		ROO	nsb	oro			Wa	shing	ton		
DIRECTOR	10a. STATE 10b. C	OUNTY		10c. CITY, TOWN OR LOCATION 10d.					10d. INSIDE CITY			
5	Maryland	Washingt	on.		Booi	nsbo	oro				- 1	LIMITS?
AL	10e. STREET AND NUMBER						10g. CI3	TIZEN OF WI	IAT COUNTRY?			
띮	8514 Old Nati	onal Pike						217	713	1	U.S.A	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. A	U.S. APMED 13. WAS DECENI			ENDENT (	OF HISPAN	IC ORIGIN? (Specify Yes		14. RACE	- American Indian.
	1 Never Married 2 Married	IF YES, GIVE Y	YES 2 X	JNO				NT, Mexicar Specify	, Puerto Rican, etc.)		Black, Specify	Whits, etc.
84	3 X Widowed 4 Divorced										,	White
15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5 +)  College (1-4 or 5 +)												
E I	Elementary/Secondary (0-12)	College (1-4 or 5	- 6	le. Do NOT u	se retired.)							
COMPL	12			I	Homema	akeı				wn H	ome	
8	17. FATHER'S NAME (First, Middle, La	st)					18. MOT	HER'S NAM	AE (First, Middle, Maiden	Sumame)		
H	Walter Mande								abeth Hei			
0	19s. INFORMANT'S NAME (Type/Print	,	1						loute Number, City or Tow			
-	Beatrice Egl	off		8514	Old 1	vati	Lona.		e, Boonsb	oro,	MD :	21713
	20a. METHOD OF DISPOSITION 1 \( \text{D} \) Burial 2 \( \text{D} \) Cremation 3 \( \text{D} \)	Removal from State		E AND DATE	OF DISPOSIT	ION (Na	me of	3/	190/193 20c. LO	CATION -	- City or Tow	n, Stats
	4 Donation 5 Other (Specify	)	Geo.	Wash:	ingto	n Me	em. 1	Park	Ply	moutl	h Mee	ting, PA
	21. SIGNATURE OF FONERAL SERVI	CE LICENSEE	)		22. N	AME AN	D ADDRE	SS OF FAC	7606	014	Mati	onal Pike
	Paul	Vn. K	land		BAS	ST E	UNE	RAL H	N MAIN.			ryland 2171
	23. PART i. Enter the diseases	, or complications the	t caused the d	iesth, Do	not enter t	he mo	de of dy	Ing. such				Approximate
	shock, or heart fal	llure. List only one ceu	ise on each lin	10.		SPIN C				atory at	, and	Interval Between
	IMMEDIATE CAUSE (Finel disease or condition		1									Onset and Death
	resulting in death)	DUE TO	(OR AS A CONS	EQUÉNCE O	relea	no	M					-
_	senere brainston cerebravas colo med											
ᅙ	Sequentially flat conditions, if any, leading to immediate	DUE TO	(OR AS A CONSI	EQUENCE O	Fi:	CO	w	ave.	oleller -	un	in	
CERTIFICATION	cause. Enter UNDERLYING	)										
Ē	CAUSE (Disease or injury that initiated events	DUE TO	(OR AS A CONSI	EQUENCE O	F):							
ᇤ	resulting in death) LAST	d										
	PART II. Other significant con-	ditions contributing to	double had not	an avilate a	to the cond	Lac.						
EDICAL	Trait in other organicate con	- Contributing to	Geeth Dat 110t	resulting	in the und	eriying	cause	given in i	Part I. 24s. WAS AN PERFOR		- 1	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
ă									1 YES 2	_ NO		COMPLETION OF CAUSE OF DEATH?
≥									_		1	T YES 2 NO
N.												
PHYSICIAN	25. WAS CASE REFERRED TO MEDIC EXAMINER?	HOSPITAL:			OTHER:		ACE OF D	EATH (Che	ck only one)			
YS	1 TYES 2 NO	1 Inpatient 2			4- Nursi	ng Hom		esidence	B C Other (Specify)			
표	27. MANNER OF DEATH  1 Natural 5 Pending	28s. DATE OF (Month, D	INJURY lay, Year)	28b. TIN	JURY		RK7		28d. DESCRIBE HOW I	NJURY OC	CURED	
₽	2 Accident Investiga	ition			М		ES 2 [	NO				
<u>a</u>	3 Suicide 6 Could n	ot be building.	F INJURY — At h etc. (Specify)	nome, farm,	street, factor	y, office	1		281. LOCATION (Street : City or Town, State)	and Numbe	or Rural Ro	ute Number,
ET												
7		PHYSICIAN: To the best of										
COMPLETED	one) 2 MEDICAL EX	AMINER: On the basis of s	xemination and/or	r Investigation	on, in my op	nion, de	eth occu	red at the i	ime, date and place, sr	d due to I	he csuse(s)	and manner as stated.
n C	29b. SIGNATURE AND TITLE OF CEL	TIFIER,				$\neg$	29c, LIC	ENSE NUM	BER	29d. DAT	TE SIGNED (	Month, Day, Ybar)
00	Much	V	4	40			D:	325	1-6	▶ 3	115/9	3
임	30. NAME AND ADDRESS OF PERSO	N WHO COMPLETED CAU	SE OF DEATH (IT)	ЕМ 27) (Тура	, Print)						/	
	Dr. R. Guedene	et, 100 Gee	ting La	ne, K	eedys	vil	le,	Marv	land 2175	56		
İ	31. DATE FILED (Mogal), Day, Year)	32. REGISTRA	R'S SIGNATURE		1	- 3 - 48	-,	1				
	MAR 1 / 1993	of wind Dands	in factil	I								



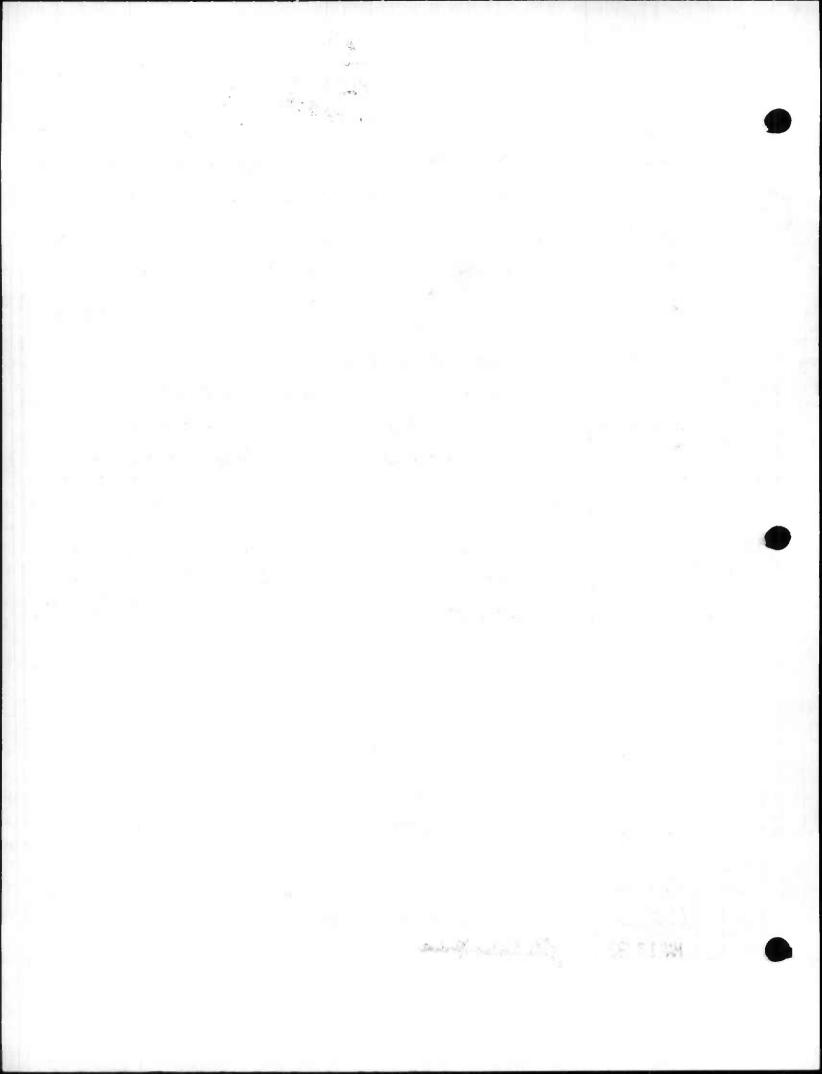
00		Leges 1, 2, 3 should	
BALTIMORE, MARYLAND 21215-0020	t hours after death. Page 6 may be retained by the hospital or attending process.	illed in by the funeral director, page 5 should be detached for use as the number of	n, or removal.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending preceding the commendation of the commendat	L DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burners.	hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, of

		1 - STATE REGISTRAR	STATE OF MAF	RYLAND / DEPAR CERTIF	TMENT OF	HEALTH AND F DEATH	MENTAL HYGIENI REG. NO.	E		
		1. DECEDENT'S NAME (First, Middle, Lest)  John Hoskins		Stone			2. DATE OF DEATH MONTH 22,	2. DATE OF DEATH MONTH 12Ch 22, 1993 YEAR 11:00 A. M		
		010 10 111/	SEX 6. /	AGE (In yrs. last birthday) 71 yrs.	IF UNDER 1 YEAR		7. DATE OF BIRTH	Tag	INTHPLACE (State or Foreign Country) MD	
2. 3 should	OR	90. FACILITY NAME (If not institution, give street Physicians Memoria	*	1		n or Location of D	EATH	9c. COUNTY C		
ges 1, 2	DIRECTOR	100 STATE 10b. COUNTY Char.	les		y, TOWN OR LO	N OR LOCATION			10d. INSIDE CITY LIMITS?	
A	FUNERAL	100. STREET AND NUMBER P.O. Box 26				101. ZIP CODE 20646			1 反 YES 2 □ NO  OF WHAT COUNTRY?  S.A.	
ing process.	BY FUN	11. MARITAL STATUS 12 11 Never Merried 2 Merried 3 Widowed 4 Divorced	WAS DECEDENT EV FORCES? 1 X V	YES 2 NO	If yes,	ECENDENT OF HISPAI specify Cuben, Mexics ES 2 NO Specif			RACE — American Indian, Black, White, etc. Specify: White	
by the hospital or attending be detached for use as the at once.	COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade cont Elementery/Secondary (0-12)	ON (pleted) (1-4 or 5+)	16a. DECEDENT'S (Give kind of v ille. Do NOT us DOCTO	vork done during se retired.)	NTION most of working	166. KIND OF BUS	iness/inousti	RY	
	BE CON	17. FATHER'S NAME (First, Middle, Last) Michael Robert:	son Stor			Bessi	ME (First, Middle, Maiden S Le Louise	Gougl		
y be retained lage 5 should be notified	TO E	Beverly Stone		P.O.	Box 2	6 LaPlat		646		
Page 6 may be il director, page		20a. METHOD OF DISPOSITION  1 Burlel & Zacremation 3 Removal 4 Donation 6 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LICENS		20b. PLACE AND DATE (	atory	2-	-22-1993			
after death. Pag y the funeral di moval.		David Cl	hola		LaP	lata,MD			OME, INC.	
within 24 hours pletely filled in the cremation, or releant, the median		23. PART I. Enter the diseases, or com shock, or heert fellure. List IMMEDIATE CAUSE (Finel disease or condition resulting in death)	plicatione that cer bnly one ceuse of	as a consequence of		node of dying, suc		retory arrest,	Approximate interval Between Onset and Death	
th certificate be ending physicia Hygiene prior or other trau	CERTIFICATION	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR	AS A CONSEQUENCE OF	10	N				
requires that the signed by of Health and shows any i	MEDICAL	PART II., Other eignificent conditions of	ontributing to dee			ing cause given in	Part I. 24a. WAS AN / PERFORI 1 YES 2	MED?	24b. WER AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?	
Inficate has e State De state	PHYSICIAN:		OSPITAL:	Outpatient 3 DOA	OTHER:	PLACE OF OEATH (Ch				
de PHYSIC ter this cer ath with th marked, u	ву РН	27. MANNER OF DEATH  1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJU (Month, Day, Ye		E OF 28c. I	NJURY AT WORK?  YES 2 NO	28d. OEȘCRIBE HOW IN	JURY OCCURE	D	
RECTOR: AI TIS after de TIS 28 IS I		3 Sulcide 6 Could not be determined	26e. PLACE OF INJ building, etc. (	URY — At home, ferm, a	treat, factory, of	fice	281. LOCATION (Street et City or Yown, State)	nd Number or Ru	irel Route Number,	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law TO THE FUNEPAL DIRECTOR: After this certificate has be filed within 72 hours after death with the State Dept.	COMPLET	29e. CERTIFIER Check only 2 MEDICAL EXAMINER: 0					to the ceuse(e) end meni		rse(a) and manner as stated.	
TO THE HE BE fied wi	TO BE (	290. BIONATURE AND TITLE OF CERTIFIER	he			29c. LICENSE NUN D-2302		29d. DATE SIG	NED (Month, Day, Year)	
		Sanjeeb K. Mishra, M.	D, 7c Pos	t Office F		nna Cente	r, Waldorf	, Md.	20602	
		31. DATE FILED (MORIT), Day, Your 93	32. REGISTRAR'S S	SIGNATURE PROBLEM	٤					

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	FOR STATE REGISTRAR	STATE OF MARYLAND / DEP	ARTMENT OF HEALTH AND	MENTAL HYGIENE REG. NO.	3 0 3 3 2 1					
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH	3. TIME OF DEATH					
	MariaN 6	Shepherd		MONTH DAY	93 2:50 AM					
		5. SEX 6. AGE (In yrs. lest birthde	y) IF UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	B. BIRTHPLACE (State or Foreign					
	177-34-9406	1 M 2 XF 82 YRS	MONTHS DAYS HOURS MIN.	(Month, Day, Year) M44 /8 /9/0	BASIN WY.					
	9a. FACILITY NAME (If not institution, give street and number)  9b. CITY, TOWN OR LOCATION OF DEATH  9c. COUNTY OF DEATH									
Ĕ.										
DIRECTOR	RESIDENCE OF DECEDENT									
RE	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CI									
		ecil	RISING SUN	/	1 TYES 2 NO					
₹ V	104. STREET AND NUMBER 101. ZIP CODE 109. CITIZEN OF WHAT COUNTRY?									
FUNERAL	1881 TELEG		2/9	11	L. S. A.					
ᆵ	11. MARITAL STATUS 1  1 Never Married 2 Married	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO	13. WAS DECENDENT OF HISPAI If yes, specify Cuban, Maxico	NIC ORIGIN? (Specify Yes or No-	14. RACE — American Indian, Black, White, etc.					
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES	1 VES 2 NO Specifi		Specify:					
	15. DECEDENT'S EDUCAT	TION 160 DECEDEN	T'S USUAL OCCUPATION	16b. KIND OF BUSINESS/INC	WHITE					
COMPLETED	(Specify only highest grade co.	impleted) (Give kind	of work done during most of working T use retired.)	IOD. KIND OF BOSINESS/INI	7031H1					
7	11 - 1		EWIFE							
o O	17. FATHER'S NAME (First, Middle, Lest)	12/00/01/		AME (First, Middle, Malden Surname)						
	JOSH G	RIFFIN	1110	" CTOUT						
BE	19a. INFORMANT'S NAME (Type/Print)		ING ADDRESS (Street and Number or Rural	Route Number, City or Town, State, Zin	Code)					
5	WILLIAM W. 5HA		2 SHADYSID 1	ON INFORM	Pa 19363					
	20e. METHOD OF DISPOSITION 1 25 Burlel 2 Cremation 3 Remove		TEOF DISPOSITION (Name of	OATE 20c. LOCATION -	City or Town, State					
	4 Donation 5 Other (Specify)		CENETERY	3/20/95 OXF	ies fa					
	21. SIGNATURE OF EUNERAL SERVICE LICEN			CILITY GEB FUNE	PAI HOME					
	17 My 6111	Ole-			TON, MO 21921					
	23. PART I. Enter the diseases, or cor	mplications that caused the death. D	o not enter the mode of dving eur	th as cardiac or manifestony an	rest, Approximata					
	shock, or heart fellure. Lis	at only one cause on each line.	41	on an outline of respiratory an	Interval Between					
	IMMEDIATE CAUSE (Final disease or condition resulting in death)  a. Congestive Heart Fracture  Licele									
	DUE TO ON AS A CONSEQUENCE OF):									
8	Sequentially list conditions, Due to consequence or sequence or se									
F	if any, leading to immediata cause. Enter UNDERLYING	CONSEGUENCE	(OF):	10	and the					
윤	CAUSE (Disease or Injury C.	DIJE TO (OR AS A CONSEQUENCE	OF:	ALC:	resourments					
CERTIFICATION	resulting in death) LAST	that initiated events  DUE TO (OR AS A CONSEQUENCE OF):								
	Carlo Carlo	DOE TO (ON AS A CONSEQUENCE								
8	d									
AL	PART II. Other algniffcent conditions	contributing to death byt not resulting	ig in the underlying cause given in		24b. WERE AUTOPSY FINDINGS					
AL	d	contributing to death byt not resulting	ng in the underlying ceuse given in	Part I. 24a. WAS AN AUTOPSY PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE					
AL	d	contributing to death byt not resulting	ig in the underlying ceuse given in	PERFORMED?	AVAILABLE PRIOR TO					
AL	PART II. Other algorificent conditions of Chronic California	contributing to death byt not resulting	ig in the underlying ceuse given in	PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?					
AL	PART II. Other algorificent conditions of Character Conditions of Character	contributing to destribut not resulting to destribution from glature Harman	est Frailure 28. PLACE OF DEATH (C)	PERFORMEO?  1 YES 2 NO	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?					
AL	PART II. Other algnificent conditions of the con	contributing to death byt not resulting	28. PLACE OF DEATH (CH.	PERFORMEO?  1 YES 2 NO  heck only one)	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?					
AL	PART II. Other algnificent conditions of the con	contributing to death but not resulting to death	28. PLACE OF GEATN (CH.	PERFORMEO?  1 YES 2 NO  heck only one)	AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH!  1 YES 2 NO					
PHYSICIAN: MEDICAL	PART II. Other algnificent conditions of the con	contributing to death but not resulting to death but not resulting to death but not resulting to the second	28. PLACE OF OEATN (Ch.  28. PLACE OF OEATN (Ch.  28. PLACE OF OEATN (Ch.  28. INJURY AT WORK?  1  YES 2 NO	PERFORMED?  1 YES 2 NO  heck only one)  6 Other (Specify)	AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH!  1 YES 2 NO					
BY PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 VES 2 NO  1 Netural 5 Pending Investigation 3 Suicide 8 Could not be	contributing to death but not resulting to death	28. PLACE OF OEATN (Ch.  28. PLACE OF OEATN (Ch.  28. PLACE OF OEATN (Ch.  28. INJURY AT WORK?  1  YES 2 NO	PERFORMED?  1 YES 2 NO  heck only one)  6 Other (Specify)	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY  1 YES 2 NO					
BY PHYSICIAN: MEDICAL	PART II. Other algnificent conditions of the con	Contributing to death but not resulting to death but not resulting to death but not resulting to the contribution of the contr	28. PLACE OF OEATN (Ch.  28. PLACE OF OEATN (Ch.  28. PLACE OF OEATN (Ch.  28. INJURY AT WORK?  1  YES 2 NO	PERFORMED?  1 YES 2 NO  neck only one)  6 Other (Specify)  28d. OESCRIBE NOW INJURY OC  28f. LOCATION (Street and Number	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY  1 YES 2 NO					
BY PHYSICIAN: MEDICAL	PART II. Other algnificent conditions of the con	contributing to death but not resulting to death but not resulting to death but not resulting to the second of the	26. PLACE OF OEATN (CA.  26. PLACE OF OEATN (CA.  26. PLACE OF OEATN (CA.  26. PLACE OF OEATN (CA.  26. PLACE OF OEATN (CA.  26. PLACE OF OEATN (CA.  27. NOTHER:  4 NOTHER:  28. PLACE OF OEATN (CA.  29. PLACE OF OEATN (CA.  20. PLACE OF OEATN (CA	PERFORMED?  1 YES 2 NO  1 YES 2 NO  6 Other (Specify)  28d. OESCRIBE NOW INJURY OC  28f. LOCATION (Street and Number City or fown, State)	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH!  1 YES 2 NO  CURED  or Rural Route Number,					
BY PHYSICIAN: MEDICAL	PART II. Other algnificent conditions of the con	Contributing to death but not resulting to death but not resulting to death but not resulting and the second secon	26. PLACE OF OEATN (CA.  26. PLACE OF OEATN (CA.  26. PLACE OF OEATN (CA.  26. PLACE OF OEATN (CA.  26. PLACE OF OEATN (CA.  26. PLACE OF OEATN (CA.  27. NOTHER:  4 NOTHER:  28. PLACE OF OEATN (CA.  29. PLACE OF OEATN (CA.  20. PLACE OF OEATN (CA	PERFORMED?  1 YES 2 NO  1 YES 2 NO  6 Other (Specify)  28d. OESCRIBE NOW INJURY OC  28f. LOCATION (Street and Number City or fown, State)	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH!  1 YES 2 NO  CURED  or Rural Route Number,					
COMPLETED BY PHYSICIAN: MEDICAL	PART II. Other algnificent conditions of the con	contributing to death but not resulting to death but not resulting to death but not resulting to the second of the	26. PLACE OF OEATN (CA.  26. PLACE OF OEATN (CA.  26. PLACE OF OEATN (CA.  26. PLACE OF OEATN (CA.  26. PLACE OF OEATN (CA.  26. PLACE OF OEATN (CA.  27. NOTHER:  4 NOTHER:  28. PLACE OF OEATN (CA.  29. PLACE OF OEATN (CA.  20. PLACE OF OEATN (CA	PERFORMED?  1 YES 2 NO  1 YES 2 NO  Contact (Specify)  28d. OESCRIBE NOW INJURY OC  28f. LOCATION (Street and Number City or Town, State)  a to the cause(a) and manner as attact time, data and place, and due to the	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH!  1 YES 2 NO  CURED  or Rural Route Number,					
BE COMPLETED BY PHYSICIAN: MEDICAL	PART II. Other algnificent conditions of the con	contributing to death but not resulting to death but not resulting to death but not resulting to the second of the	28. PLACE OF OEATN (CHAPTER)  28. PLACE OF OEATN (CHAPTER)  28. PLACE OF OEATN (CHAPTER)  28. PLACE OF OEATN (CHAPTER)  28. PLACE OF OEATN (CHAPTER)  28. PLACE OF OEATN (CHAPTER)  28. PLACE OF OEATN (CHAPTER)  28. PLACE OF OEATN (CHAPTER)  28. PLACE OF OEATN (CHAPTER)  28. PLACE OF OEATN (CHAPTER)  28. PLACE OF OEATN (CHAPTER)  28. PLACE OF OEATN (CHAPTER)  28. PLACE OF OEATN (CHAPTER)  28. PLACE OF OEATN (CHAPTER)  28. PLACE OF OEATN (CHAPTER)  29. PL	PERFORMED?  1 YES 2 NO  1 YES 2 NO  Contact (Specify)  28d. OESCRIBE NOW INJURY OC  28f. LOCATION (Street and Number City or Town, State)  a to the cause(a) and manner as attact time, data and place, and due to the	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH!  1 YES 2 NO  CURED  or Rural Route Number,					
COMPLETED BY PHYSICIAN: MEDICAL	PART II. Other algnificent conditions of the con	Contributing to death but not resulting to the state of my knowledge, death occord to the basia of examination end/or investign the state of the basia of examination end/or investign.	26. PLACE OF OEATN (CA. A.	PERFORMED?  1 YES 2 NO  1 YES 2 NO  Contact (Specify)  28d. OESCRIBE NOW INJURY OC  28f. LOCATION (Street and Number City or Town, State)  a to the cause(a) and manner as attact time, data and place, and due to the	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH!  1 YES 2 NO  CURED  or Rural Route Number,					
BE COMPLETED BY PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATN  1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined  29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:  29b. SIGNATURE AND TITLE OF CERTIFIER  30. NAME AND DDRESS OF PERSON WHO COULD THE COURT OF THE COULD THE COURT OF T	Contributing to death but not resulting to the state of t	26. PLACE OF OEATN (CA. A.	PERFORMED?  1 YES 2 NO  1 YES 2 NO  Contact (Specify)  28d. OESCRIBE NOW INJURY OC  28f. LOCATION (Street and Number City or Town, State)  a to the cause(a) and manner as attact time, data and place, and due to the	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH!  1 YES 2 NO  CURED  or Rural Route Number,					
BE COMPLETED BY PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 VES 2 NO  1 Netural 5 Pending Investigation  3 Suicide 8 Could not be determined  29a. CERTIFIER (Check only one)  29b. SIGNATURE AND TITLE OF CERTIFIER	Contributing to death but not resulting to the state of t	26. PLACE OF OEATN (CA. A.	PERFORMED?  1 YES 2 NO  1 YES 2 NO  Contact (Specify)  28d. OESCRIBE NOW INJURY OC  28f. LOCATION (Street and Number City or Town, State)  a to the cause(a) and manner as attact time, data and place, and due to the	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH!  1 YES 2 NO  CURED  or Rural Route Number,					

DIVISION OF VITAL RECORDS, P.O. BOX 68760,



1	-	FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCICAE

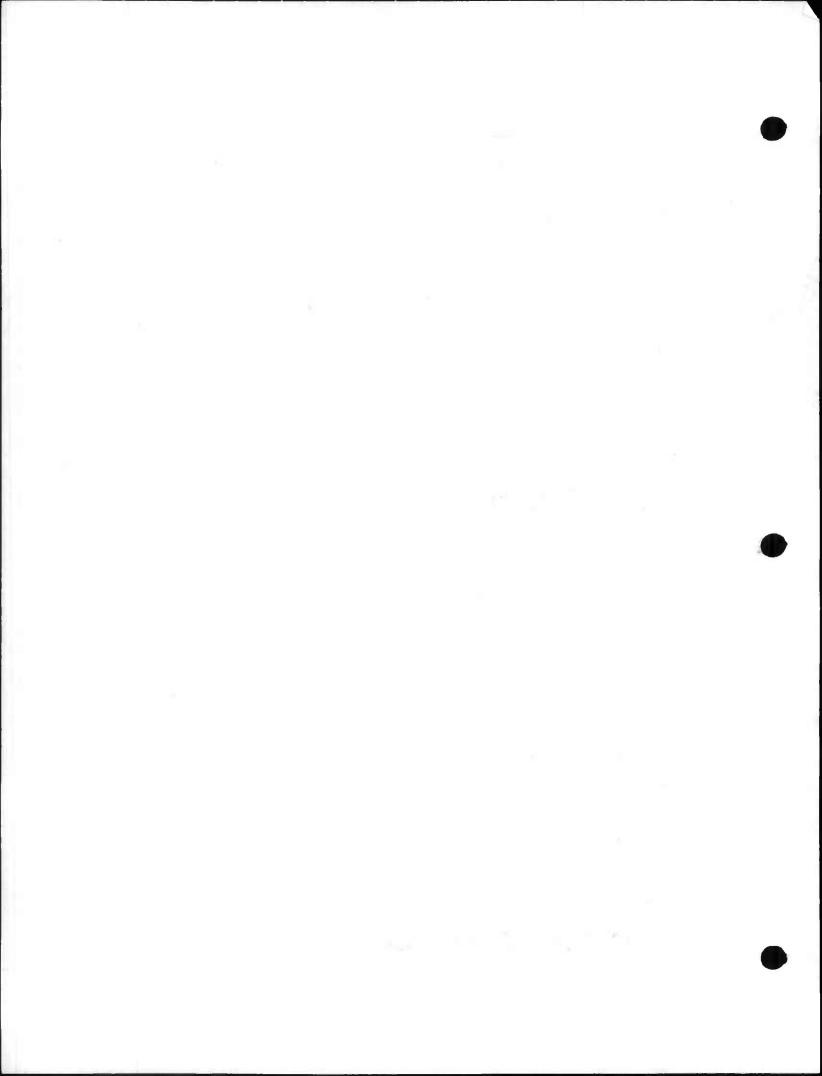
	1 - STATE REGISTRAR	OINIE OF MAIL		ICATE OF		REG. N				
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH			3. TIME OF DEATH			
	GOLDIE	MER	EA SHI	REVE		MARCH	18 1	YEAR QQ3	00.50 A.	
	The state of the s	SEX 6. AG	E (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		6. BIRTH	IPLACE (State or Foreign	
	213-40-4034	□ M 2 💓 F	73 YRS.	MONTHS DAYS	HOURS MIN.	MAY 21 1	19	MA	RYLAND	
	9a. FACILITY NAME (If not institution, give street			9b. CITY, TOWN	OR LOCATION OF D	EATH	9c. CO	UNTY OF D	EATH	
OR	SACRED HEART HOSPI	TAL		CIIM	BERLAND.	MD	AT.	LECAN	737	
DIRECTOR	RESIDENCE OF DECEDENT  10a, STATE  10b, COUNTY		100 00	Y, TOWN OR LOCA			I AL	LEGAL	-	
E		LEGANY		LINTSTO					10d. INSIDE CITY LIMITS?	
	10e. STREET AND NUMBER	LEGANI			Y. ZIP CODE		40.00		1 TES 2 NO	
FUNERAL	BOX# 142			,"	21530		10g. Cr	U.S.	WHAT COUNTRY?	
5		2. WAS DECEDENT EVER FORCES? 1   YE					Yes or No-	14. RACI	E — American Indian,	
BY	1 Never Married 2 Married XX Widowed 4 Divorced	IF YES, GIVE WAR OR			S 2 NO Specif				WHITE	
B	15. DECEDENT'S EDUCAT (Specify only highest grade co		18a. DECEDENT'S	USUAL OCCUPAT	ON	16b. KIND OF I	BUSINESS/IN	IDUSTRY		
ᄪ		College (1-4 or 5+)	(Give kind of life, Do NOT u	work done during m se retired.)	ost of working	-				
I I	8		CUMBER	LAND BLO	DUSE FACT	ORY I	RESSE	ER		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maid	en Sumame)			
BE (	ELMER ANDREW CL	INGERMAN				IAY MORGAN				
6	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or 1				
-	GERALDINE M. DIX		RFD#	2 BOX# .	L41 FLINT	STONE, MA	RYLAN	1D 2	1530	
	20a. METHOD OF DISPOSITION  1  Burial 2  Cremation 3  Remove	of from State	0b. PLACE AND DATE	OF DISPOSITION (A	ame of	DATE 20c.	LOCATION -		· ·	
	4 Donation 5 Other (Specify)		GLENDALE'	7			LINTS	TONE	, MARYLAND	
	21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE			ND ADDRESS OF FA	FUNERAL	HOME			
	Wale L.	estrett				TREET CUN		ND.	MARYLAND	
	23. PART I. Enter the diseases, or cor shock, or heert fellure. Lis	pilcetions that caus	ed the death. Do						Approximate	
	Interval Between Onset and Death    Compared to the control of the									
z										
CERTIFICATION	Sequentially list conditions, If any, leading to immediate  b. // // // // // // // // // // // // //									
CA	CAUSE (Disease or Injury									
빌	that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE O	F):						
H	d.									
	PART II. Other significant conditions	contributing to death	but not resulting	in the underlyir	g ceuse given in	Part I. 24s. WAS	AN AUTOPSY	24b	. WERE AUTOPSY FINDINGS	
DICAL	Portal Hypen	tension:	Coasn	16 pat	7.		ORMED?		AMAILABLE PRIOR TO COMPLETION OF CAUSE	
ш			1	- Comment	7	1 YES	2 PKNO		OF DEATH?	
Σ						_			1   YES 2   NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL			26. P	LACE OF DEATH (Ch	eck only one)				
Sic	EXAMINER?	IOSPITAL:	utastient 3 🗆 DOA	OTHER:		6 Other (Specify)				
¥	27. MANNER OF DEATH	28a. DATE OF INJUR	Y 28b. TIN	E OF 28c. IN	JURY AT	28d. DESCRIBE HON	Y INJURY O	CCURED		
ВУР	1 Netural 5 Pending	(Month, Day, Year	) IN.		ORK7 YES 2 NO					
	3 Suicide 6 Could not be	28a. PLACE OF INJU	RY — At home, ferm,	street, factory, offi	te	281. LOCATION (Size	et and Numbe	or Rural F	Route Number,	
	4 Homicide determined	building, etc. (S)	ouchy)			City or Town, Sta	(w)			
COMPLET	29a. CERTIFIER Check only	N: To the best of my kno	owledge, death occurr	ed at the time, dat	and place, and due	to the cause(s) and s	tenner ee et	stad		
₹ I	one) 2 MEDICAL EXAMINER:								and menner as stated.	
	296. SIGNATURE AND TITLE OF CERTIFIER	- //	-		29c. LICENSE NUI					
8	1/2 6	El.	10/		MD 3	C^/> c-	290, DA	Z /IN	(Month, Day, Year)	
임	36. NAME AND ADDRESS OF PERSON WHO C	COMPLETED ENAISE OF I	DEATH (ITEM 27) (Now	Prints	11/2/3	(2)		21101	75	
	Thomas E.	harm 111	MO 91	7 504	Dr.	Cum	60-	1	/	
- 1	at here are a large of the same	34. A STRANDSI	NATURE -	2 1016	701	am	000	Capa	1 M	
ļļ.	31. DATE FILE AND DEL 101 101	72. 10 S 10 S 10	ATTAI OTTIL							

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burnal-trained filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. 6

BALTIMORE, MARYLAND 21215-0020

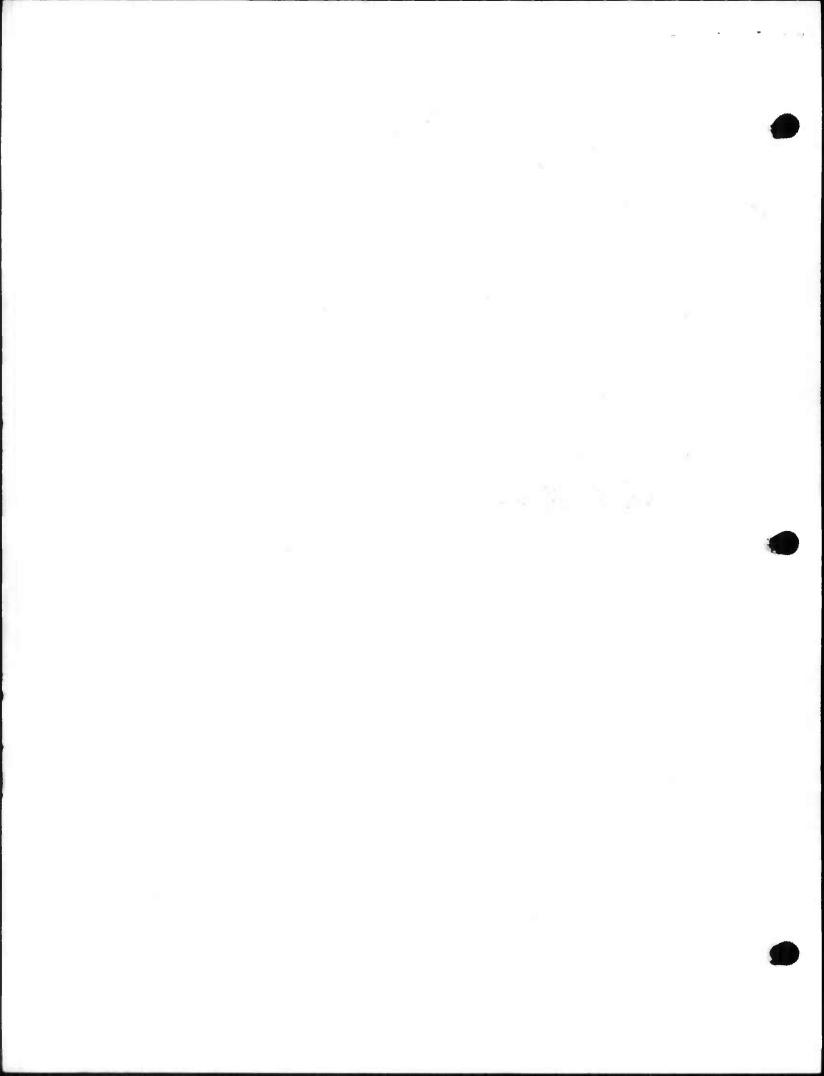
DIVISION OF VITAL RECORDS, P.O. BOX 68760,



TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE MOSPITAL OB ATTENDING PHYSICIAN. The law renders that the death certificate be executed within Jours after death. Page 8 may be retained by the hospital	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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1 - FOR STATE REGISTRAR		STATE OF MARY		TMENT OF		MENTAL	HYGIENE REG. NO.			
1. DECEDENT'S NAME (First		ROBERT W.	TADMAN.	TTT		2. DATE O MONTH	F DEATH DAY	YEAR	3. TIME OF DEATH	
222-07-34	4. SOCIAL SECURITY NUMBER  222-07-3434  1 Mm 2 F  90. FACILITY NAME (If not institution, give street and number)		6. AGE (In yrs. lest birthdey) F UNDER 1 YEAR FU MONTHS DAYS HOU		F UNDER 24 HRS. HOURS MIN. OR LOCATION OF DE	UNDER 24 HRS. 7. DATE OF BIRTN (Month, Day, Year)  11-11-14		Cou	8. BIRTINPLACE (State or Foreign Country) Del. NTY OF DEATH	
	14 Capetown Rd.				lin			Worce	ester	
10e. STATE Md.	10b. COUNTY WOTCE	ester		y, town or Loca Berlin	TION				10d. INSIDE CITY LIMITS? 1 - YES 2 NO	
	10. STREET AND NUMBER 14 Capetown rd.				21811			Og. CITIZEN OF USA	WHAT COUNTRY?	
	11. MARITAL STATUS  1 Never Merried 2 Merried  3 Wildowed 4 Divorced  12. WAS DECEDENT EVER IN U.S. AR FORCES? 1 FYES 2 N IF YES, GIVE WAR OR DATES			if yes, s	CENDENT OF HISPAI pecify Cuben, Mexica S 2 NO Specifi	in, Puerto Ri		814	CE — American Indian, ack, White, atc. ecity: White	
(Specify or	(Specify only highest grade completed) (Gillientermany/Secondary (0-12) College (1-4 or 5+)			ECEDENT'S USUAL OCCUPATION She kind of work done during most of working a. Do NOT use retired.) EXECUTIVE			186. KIND OF BUSINESS/INDUSTRY Banking			
17. FATHER'S NAME (First, Robert V		n, Jr.			18. MOTHER'S NA			rname)		
190. INFORMANT'S NAME Suzanne I	***	L		JLING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Capetown Berlin, Md., 21811						
20e, METNOD OF DISPOSI 1 September 2 Cremet 4 Donellon 5 Other	on 3 K Remova r (Specify)	I from State	other place)  Grace	lawn Cer	neterv			TION — City or minator		
21. SIGNATURE OF FUNER	AL SERVICE LICEN	sil			ano adoness of Fa lrich Fun		Home	Berlin	n, Md.	
23. PARY I. Enter the shock, or iMMEDIATE CAUSE (F disease or condition resulting in death)	naert fellure. Lis	t only one ceuse on	and the death. Do and line.	2 0	rest	ch es cerdi	ec or respirat	tory errest,	Approximata interval Batweer Onset and Deati	
if any, leading to Imm ceuse. Entar UNDERL CAUSE (Disease or In that initiated events	Sequantially list conditions, if any, leading to immediate ceuse. Entar UNDERLYING CAUSE (Disease or Injury c.									
PART II. Other algorition	ant conditions	contributing to death	but not resulting	resulting in the underlying ceuse given in Par			PERFORMED?  1 YES 2 NO OF DEA		14b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2 NO	
25. WAS CASE REFERRED EXAMINER?					PLACE OF OEATN (C	heck only one	)			
1 YES 2 NO		OSPITAL:			me 5 🗆 Residence					
27. MANNER OF DEATH  1 Natural 5  2 Accident	Pending Investigation	28s. DATE OF INJURY (Month, Day, Year	) IN	M 1	IJURY AT YORK?   YES 2   NO	28d. DE\$(	CRIBE NOW INJ	URY OCCURED		
2   Accident 3   Suicide 4   Nomicide  2e. CERTIFVING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and menner se stated.  2   Accident 3   Suicide 4   Nomicide  2e. CERTIFVING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and menner se stated.  2   MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and menner se stated.						al Route Number,				
(GINGER ONLY)		N: To the best of my kno							e(s) end menner ee stated.	
29b. SIGNATURE AND TITI	E OF CENTHFIER	~		-	29c. LICENSE NU	MBER 974		≥ 3-	160 (Month, Day, Year)	
30. NAME AND ADDRESS	alas i	Bruce	mD.		Old Ocea	an a	ty Bli	id B	erlew md	
31. DATE FILED (Month, Da	1003	Julia Denida	on-Randalla							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, be filled within 72 hours after death with the State Dept. of Health and Menhal Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS P.O. BOX 68760,

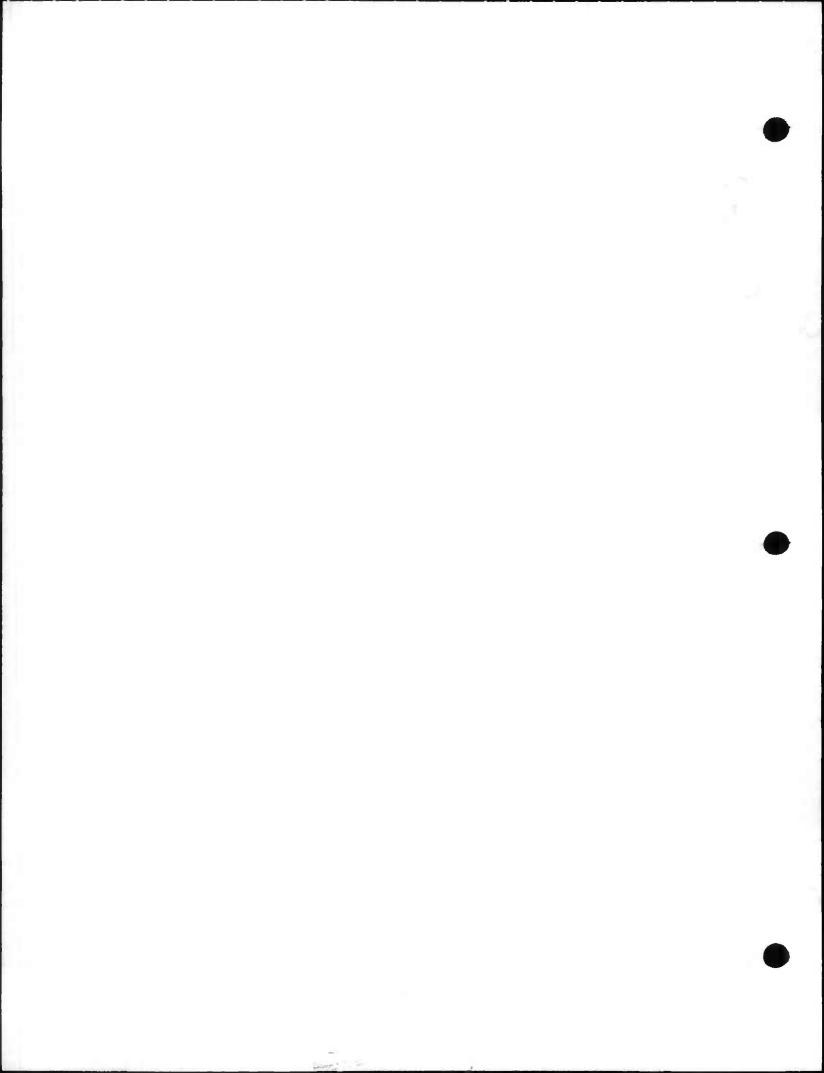
TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1	-	FOR STATE REGISTR	AR
1	1. DI	ECEDENT'S	NA

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1 - STATE REGISTRAR		CE	RTIFIC	CATE O	DEATH	D MILIT	REG. NO.				
1. DECEDENT'S NAME (First, Middle,	Last)	-					TE OF DEATH	.v	YEAR	3. TIME OF DEATH	
Nancy Ann	Boss TOPP						03 1		993	7:05P	M
4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. last i		IF UNDER 1 YEAR		S. 7. DA	TE OF BIRTH		8. BIRTH Countr	IPLACE (State or Forei	ign
578-38-1320	1 🗆 M 2 💢 F	64	YRS.	- CAY	HOURS MIN	0	8/04/19	28	Was	hington,	DC
96. FACILITY NAME (N not institution, Doctors Communi	ty Hospital			Lanh	OR LOCATION OF	DEATH			NCE (	eath George	J
RESIDENCE OF DECEDEN	DUNTY		10c. CITY	TOWN OR LOC	ATION					10d. INSIDE CITY	
California Sa	an Diego			n Dieg						LIMITS?	_
10e. STREET AND NUMBER	2.090		Jai		IOF. ZIP CODE			10a CIT	IZEN OF V	1X YES 2 NO	0
1970 Linwood S					92110				U.S.		
11. MARITAL STATUS  1 Never Married 2 Married  3 Widowed 4 Divorced	12. WAS DECEOENT FORCES? 1 [ IF YES, GIVE WA	YES 2 XHO	ED )	If yes,	ECENDENT OF HIS specify Cuben, Mei ES 2 X NO Sp	rican, Puer	GIN? (Specify Yes to Rican, etc.)	or No	14. RACI Black Spec	E — American Indian, k, White, etc.	
										White	
15. DECEDENT'S (Specify only highest	grade completed)	(GM	kind of wo	SUAL OCCUPA rk done during i retired.)	TION most of working		16b. KIND OF BUS	BINESS/IN	DUSTRY		
Elementary/Secondary (0-12)	College (1-4 or 5+)						D .			. 1	
17. FATHER'S NAME (First, Middle, Let		Com	ipute	r Proc	rammer		Depart		of	the Navy	
Ernest Boss	"/						izabeth			a al	
19a, INFORMANT'S NAME (Type/Print)		196	MAILING A	nnness (Street	t and Number or Ru					iu	
Janet Talbert										land 207	82
20a. METHOD OF DISPOSITION		20h PLACE AN	ID DATE OF	DISPOSITION	Name of		ATE 20c 10	CATION -	City or To	wn State	
1 Donation 5 Other (Specify)		Metro	polit	an Cre	ematory	3/13	/93 Ale	xanc	Iria	Virginia	
21. SIGNATURE OF FUNERAL SERVI	CE LICENSEE	1	/	22. NAME	AND ADDRESS OF	FACILITY					
	n Ke	uft		473	9 Baltim	ore	Avenue	. H\	atts	Home, P ville, MD	. A .
immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury  LESSALON of Vendlt Support Standy T. Livy Welf  CAUSE (Disease or Injury)										
PART II. Other significant cond	ddltions contributing to c	leeth but not res	sulting in	the underivi	no cause given	in Part I	24a. WAS AN	ALITOPSY	245	. WERE AUTOPSY FIND	SOME
	Surger						PERFOR			MAILABLE PRIOR TO COMPLETION OF CAU OF DEATH?  1 YES 2 NO	) USE
25. WAS CASE REFERRED TO MEDIC EXAMINER?	HOSPITAL:				PLACE OF OEATH	(Check only	one)				
1 TYES 2 TNO	1 🖾 inpatient 2 🗆			OTHER:	me 5 🗆 Residen	ce 8 🗆 O	ther (Specify)				
27. MANNER OF OEATH  1 Natural 5 Pending 2 Applies Investigs	28a. DATE OF II (Month, Day	NJURY (, Year)	28b. TIME INJUI	RY V	VORK?	28d. 0	DEȘCRIBE HOW II	VJURY OC	CURED		
2 Accident investiga 3 Suicide 8 Could ru 4 Homicide determin	28e. PLACE OF building, e	INJURY — At hom tc. (Specify)	a, farm, str	eet, factory, of	ice	28t, L	OCATION (Street stity or Town, State)	and Number	or Rural F	Route Number,	
	PHYSICIAN: To the best of m									ı) and manner sa stat-	ed.
296. SIGNATURE AND TITLE OF CER	TIPLER				29c. LICENSE I	NUMBER	,	29d. DAT	E SIGNED	(Month, Day, Year)	$\dashv$
30. NAME AND ADDRESS OF PERSO					1235	06	es pa	1	9/17	7.7	
31. PATE FILED (Month, Day, Year) MAK 1 5 1993		223 A		PLU	7	uise	16	7	101	1()	$\dashv$



page 5 should be detached for use as the burial-transit

funeral director,

hours after death. Page 6 may be retained by the hospital or attending physician.

**BALTIMORE, MARYLAND 21215-0020** 

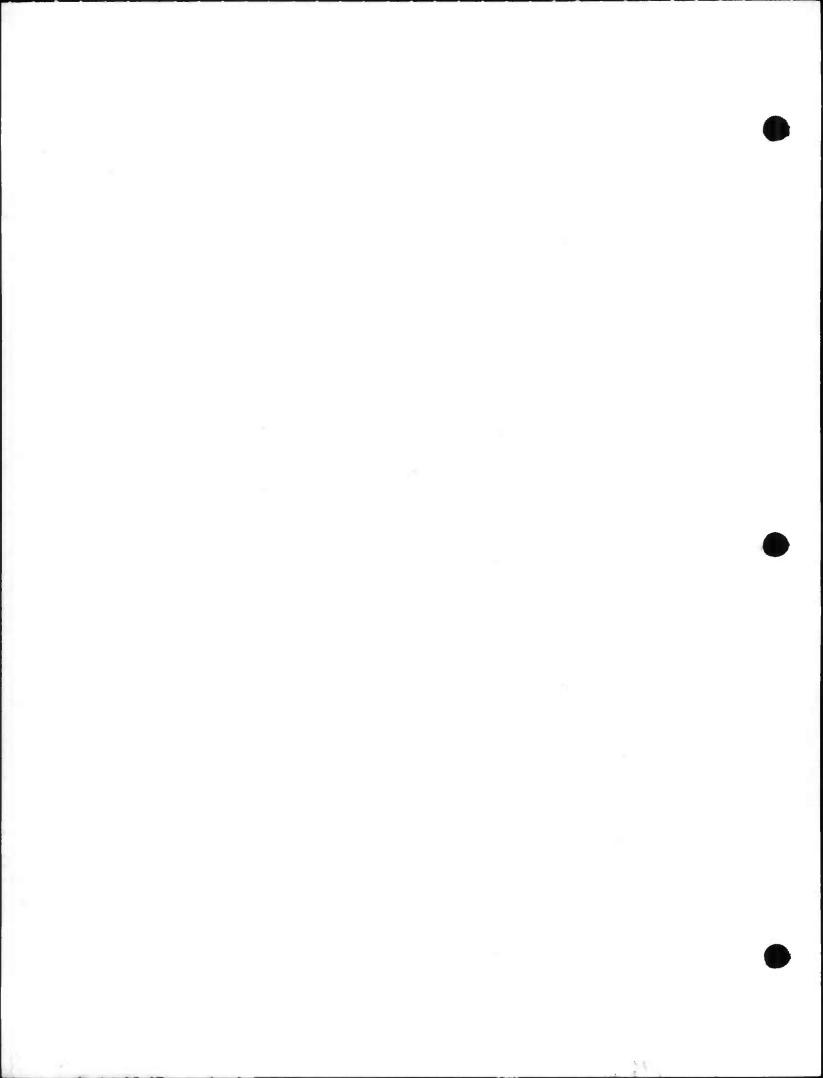
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00,	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fi	filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	petra	Com	inal.
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	出	THE	fled

signed by the

this c

death

FOR STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF CEATH MONTH 3 YEAR WINIFRED HACKLEY TURNER 16 1993 12:00 P 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 1 🗌 M 2 😡 F 216-50-7048 6-24-1918 Virginia 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 3119 Madison Street Hyattsville Prince George's RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY LIMITS? Maryland Prince George's Hyattsville 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3119 Madison Street 20782 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Maxican, Puerto Rican, atc.) 14. RACE — American Indian, Black, White, atc. ORCES? 1 YES 2
YES, GIVE WAR OR DATES FORCES? 2 X NO 1 Never Married 2 X Married BY 1 YES 2 X NO Specify. 3 Widowed 4 Divorced White COMPLETED 15. OECEDENT'S EDUCATION (Specify only highest grade complet 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Clarence Lanham Louise BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 John Marvin Turner, Sr. 3119 Madison Street, Hyattsville, MD 20782 pe 20e. METHOD OF OISPOSITION
1 □ Burlel 2 ☒ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must Metropolitan Crematory 3/18/93 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) examiner 22. NAME AND ADDRESS OF FACILITY
Francis Gasch's Sons Funeral Home, P.A. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE mm 4739 Baltimore Ave., Hyattsville, MD 20781 medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or reepiratory arrest, Approximata ehock, or heart fellure. Liet only one cause on each line. intarvai Between IMMEDIATE CAUSE (Final **Onset and Death** the disease or condition CARCINOWA 6 10189 Colon resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events injury, or other DUE TO (OR AS A CONSEQUENCE OF): resulting in deeth) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE 24a. WAS AN AUTOPSY PERFORMED? been signed by pt. of Health and shows any i OBSTRUCTIVE CHRONIC 1 TYES 2 NO OF OEATH? 1 YES 2 NO PHYSICIAN: certificate has be h the State Oept. of d, or item 23 sl 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 PNO 1 Inpatient 2 ER/Outpatient 3 DOA 4 - Nursing Home 5 Residence 8 - Other (Specify) 27. MANNER OF OEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending В 1 YES 2 NO 2 Accident hours after desitem 28 is n 28s. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 3 Suicide ETED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide Hem 29s. CERTIFIER
(Check only 1 (CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. COMPL ID THE FUNERAL C filed within 72 h 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated, 29b. SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER BE 29d. OATE SIGNEO (Month, Day, Year) Control oga B. 1 3 118 205891 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROGER INGHIM M.O. REMILLIERTH AUS RIVERPALE 6510 32. REGISTRAR'S SIGNATURE
JUNIA DAVIDSON-ROMARE



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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hr	DIRECTOR. Advantages and the form of the second sec
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1	1. DECEDENT'S NAME (First, Middle, Last)  2. DATE OF DEATH  3. TIME OF DEATH													
- 1	DOROTHY MARIE TRUAX								WONTH 13AY 93EAR 1 TIME			10:00A		
	4. SOCIAL SECURITY NUMBER		5. SEX 8. AGE (In yrs. le		s. last birthday) IF UNDER 1		1 1 YEAR	EAR IF UNDER 24 HRS.		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign		
	579-24-5668		1 🗆 M 2 💢 F	□ M 2 [XF 88		MONTHS	DAYS	HOURS &	WIN.		(Month, Day, Year)		ketts, VA	
	90. FACILITY NAME (If not in	stitution, give st	reet and number)			9b. CITY	r, TOWN	OR LOCATION		<u>01-01-190</u> H		INTY OF O		
E C	PRINCE GEORGE'S HOSPITAL CENTE					Cl	HEVE	RLY					GEORGE	
DIRECTOR	RESIDENCE OF DEC													
R	10a. STATE		10c. CIT	Y, TOWN	OR LOCA	TION					10d, INSIDE CITY			
0	Maryland   Prince George's					dens	bur	g					1 X YES 2 NO	
M	10e. STREET AND NUMBER	101. ZIP CODE						TIZEN OF V	VHAT COUNTRY?					
FUNERAL	5300 Tilden	Road						2071	0			U.S.	Α.	
5	11. MARITAL STATUS 1 Never Married 2		12. WAS DECEDEN FORCES? 1	T EVER IN U.S. AR	I IN U.S. ARMED 13. WAS			ENDENT OF H	HISPANIC	ORIGIN? (Specify Yes Puerto Rican, etc.)	or No-	- American Indian, t, White, etc.		
B	3 X Widowed 4 Divo		IF YES, GIVE W	AR OR DATES	DATES 1 YES 2 X NO Spec					out of the state o		Speci		
	15 OFC	EDENT'S EDUC	CATION	1 440 OF	CERENTIA	1001111 0						1	wnite	
	(Specify only	highest grade	completed)	(Gi	CEDENT'S ive kind of a Do NOT us	work done	during me	ost of working		16b. KIND OF BU	SINESS/IN	DUSTRY		
1	Elementary/Secondary (0	-12)	College (1-4 or 5 d	7)						Own	Uama			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				Housewife					(First, Middle, Maiden		:		
	William Henr		wn							lizabeth (		a a la	100	
BE	19a. INFORMANT'S NAME (7)		44.11	191	MAILING	ADDRES	S /Street :		_	ite Number, City or Tow				
2	Anna M. All												and 20740	
	204 METHOD OF DISPOSITI	ON		20h PLACE	ND DATE	OF OISPOS	RITION (M	me of		DATE 200 LO	CATION	Other on To	our State	
	1 XBuriel 2 Crematio	n 3 🗆 Remo	oval from State	cemetery, cre	matory or o	ther place)	Com	otory	2/1	0/02 D	-	. City or 10	Maus Iand	
	21. SIGNATURE OF FUNERAL	t Lincoln Cemetery 3/18/93 Brentwood, Maryland												
	· Jack & Frens					Francis Gasch's Sons Funeral Home, P.A.								
	23. PART / Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,   Approximate													
	IMMEDIATE CAUSE (Fin disease or condition	eert fallure. I	List only Dne cau	se on each iine					,			,	Interval Between Onset and Death	
	displace or condition resulting in death)  a. Augination freumanie  Due to (on as a consequence of):													
z														
은	Sequentially list conditione, If any, leading to immediate  DUE TO (OR AS A CONSEQUENCE OF):													
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury													
E	that initiated events		DUE TO	(OR AS A CONSEC	UENCE O	F):								
	resulting in death) LAS		1											
	PART II. Other significe	nt conditions	s contributing to	death but not n	acultina.	in the ur	dorbile	a navan alı	on in the	-1   a. maa				
MEDICAL	PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse give							en in Pa	ert I. 24a. WAS AN PERFOR		246.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO		
		14						1 TYES 2 NO OF DEATH?					OF DEATH?	
~ 1										_			1 TYES 2 NO	
AN	25. WAS CASE REFERRED TO	MEDICA: I												
2	EXAMINER?	MEDICAL	HOSPITAL:		26. PLACE OF DEATH (C)									
PHYSICIAN:	1 TYES 2 THO		1 □ Inpatient 2 □		DOA 28b. TIM	4 CATur	28c. INJ			Other (Specify)				
	-/	Pending	(Month, D	ay, Year)	200. IM	URY	WC	PRK?		8d. DESCRIBE HOW I	NJURY OC	CURED		
B	2 Colores	nvestigation	28e, PLACE O	F INJURY — At ho	ne form	street fact			_	28f. LOCATION (Street and Number or Rural Route Number.				
COMPLETED		Could not be determined	building,	atc. (Specify)		MIGGE, 1861	iory, ornic	•	1	City or Town, State)	ina Numbe	r or nuner	loute Number,	
9	29a. CERTIFIER													
N N	(Check only									the cause(s) and mer				
ខ្ច	2   MEDI	CAL EXAMINE	CON The Deals of at	ramination and/or i	nvestigatio	en, In my o	opinion, d	eath occured	at the tim	ne, data and place, an	d due to t	he cause(a	) and menner as stated.	
w II	296. SIGNATURE AND TITLE	OF CERTIFIER	1 A	+ tend .	p 1L	4110	in	29c. LICENS	E NUMBE	R	29d. DA	TE SIGNED	(Month, Day, Year)	
10 8	wind.	4-	1/	A LA	1 1	1		125	0/		17	1/11/	73	
	30. NAME AND ADDRESS OF	DLONG			4 27) (Type	Print)	nbe	14 RJ	1. 0	ruite 101	Jec	Lrach	ma 2.706	
	31. DATE FILED (Month, Day, MAR 1	7 1993	32. REGISTRA	Paydon-l	Pande	æ								

	THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ZATIOUS after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pane 5 should be desarried		/IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	
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•	I with	mplet	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	vent	1
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	1 - STATE REGISTRAR	3	IAIE UF N	MANTLAN	CERTIF	ICATI	I UF H	DEAT	AND M	MENTA	L HYGIEN	Ę			
	1. OECEDENT'S NAME (First, Mid	idle, Last)			OLITIN	IOAII	_ 01	DEA	1	2. DATE	REG. NO.			3. TIME OF DEATH	
	Obie Rudl						March 12, 1993 3			3:00 P M					
	231-05-0219	3. 5	M 2   F	6. AGE (In y	rs. lest birthday) YRS.	IF UNDER	DAYS	HOURS	MIN.	7. DATE	of BIRTH th, Day, Year) le 5, 1	917	Countr	PLACE (State or Foreign y) Sex Cty. Va.	
	9e. FACILITY NAME (If not institut	tion, give street e	nd number)			9b. CITY	, TOWN C	R LOCATIO	ON OF DEA		, I		NTY OF D	-	
OR	12000 River		1.			Ft	. Wa	shin	gton			PG			
DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNTY				10c CIT	Y, TOWN (	DR LOCAT	ION							
DIR	Maryland PG					. Wa								10d. INSIDE CITY LIMITS?	
AL	10e. STREET AND NUMBER					• 114		ZIP CODE		18g, CITIZEN OF			ZEN OF W	1X YES 2 □ NO	
ER	12000 River	view Ro	i.				2	0744		USA					
BY FUNERAL	11. MARITAL STATUS  1 Never Married 2 Meri 3 Widowed 4 Divorced	ried	WAS DECEDENT FORCES? 1 F YES, GIVE W	YES 2	! □NO		If yes, spe	city Cuber	OF HISPANIC n, Mexicen, Specify:	IIC ORIGIN? (Specify Yea or No- 14. RACE - Black, Black,			- American Indian, White, etc.		
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	Junius Tonki	,,									Middle, Malden S las Tol	,			
8	190. INFORMANT'S NAME (Type/F				19h MAII ING	ADDRESS	Ctmot a				ber, City or Town				
임	Evangeline Mu	rphy			12000	Rive	ervi	ew Ro	f Ft.	Wa	sh., Mo	1. 20	)744		
	20a, METHOD OF OISPOSITION  1 M Suriel 2 Cremetton 3 Removel from State  20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, cremetory or other place)  20c. LOCATION — City or Town, State														
	21. SIGNATURE OF FUNERAL SERVICE (RENSE)  Maryland Vet Cemetery 3-18 Cheltenham PG Maryland 23. NAME AND ADDRESS OF FACILITY Plunkett Funeral Home														
	Plunkett Funeral Home 2504 28th Street, N. E., Wash., D. C.														
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, ahock, or heart failure. List only one cause on each line.  Approximate interval Between														
	IMMEDIATE CAUSE (Finel							40.0		-				Onset and Death	
	resulting in death)  a. CARDIO PULMON ART ARREST  DUE TO (OR AS A CONSEQUENCE OF):														
CERTIFICATION										12 MONTHS					
CAI	cause. Enter UNDERLYING CAUSE (Disease or Injury	ELLE	ALIA	12	Cr	Anc.	INOMA				PHTHOMEY				
that Initiated events  DUE TO (OR AS A CONSEQUENCE OF):  resulting in death) LAST												751107175			
5	d.														
31	PART II. Other aignificent co	onditions con	tributing to	death but n	ot reaulting i	n the un	derlying	ceuse g	iven in P	nrt í.	24a. WAS AN A PERFORM			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
MEDICAL											1 YES 2 70			COMPLETION OF CAUSE OF DEATH?	
														1 TYES 2 NO	
AN	25. WAS CASE REFERRED TO ME	DICAL													
2	EXAMINER?  1  YES 2 NO	но	SPITAL:	EB/Outpetter	4 4 7 804	OTHER	1.		ATH (Check						
PHYSICIAN:	27. MANNER OF DEATN		28e. DATE OF	NJURY	28b. TIMI	OF	28c. INJU		sidence 6			ILIBY OCC	LIBED		
4	1 Natural 5 Pendi		(Month, De	y, Year)	INJ	JRY M	WOR	K?		28d. DESCRIBE HOW INJURY OCCURED					
	2 Accident Investigation 3 Suicide 8 Could not be datermined Categorium 1 Tes 2 NO  28e. PLACE OF INJURY — At home, ferm, atreet, factory, office building, etc. (Specify)  28f. LOCATION (Street end Number or Rural Route Number, City or Yown, State)									oute Number,					
COMPLETED	29e. CERTIFIER (Check only one)	IG PNYSICIAN:	To the best of n	ny knowledge	, death occurre	d at the ti	me, date e	nd place,	end due to	the cau	se(e) end mann	er es atate	d.		
3	2 MEDICAL	EXAMINER: On	the basis of exa	amination end	L'or investigation	n, in my o	pinion, de	nth occurs	d at the tin	ne, date	and place, end	due to the	ceuse(s)	end menner ee stated.	
N N	Harold F. R	ERTIFIER	MD				1	29c. LICEN	NSE NUMBI	ER	- >	29d. DATE	SIGNED (	Month, Day, Year)	
2	30. NAME AND ADDRESS OF PER	ISON WNO COM	PLETED CAUSE	OF DEATH	(ITEM 27) (Type,	Print)	- 12	-	# / /	23	5	- 3	117	173	
	HAROLD F	RE	TLLT	MI	) V	AN	1EN	CF	VIDEA	0	50 TA	VINL	157	NW DC. 204	
	31. DATE THE PROPERTY Day 716 and	203		SIGNATUR	Danda 00		10						,	20.209	

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	BALLIMORE, MARYLAND 21215-0020	ours after death. Page 6 may be retained by the hospital or attending physician.	I in by the funeral director, page 5 should be detached for use as the burlaf-transit permit.
SOURCE STATE OF COLORS	DIVISION OF VITAL RECORDS, P.O. BOX 68760,	. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit.

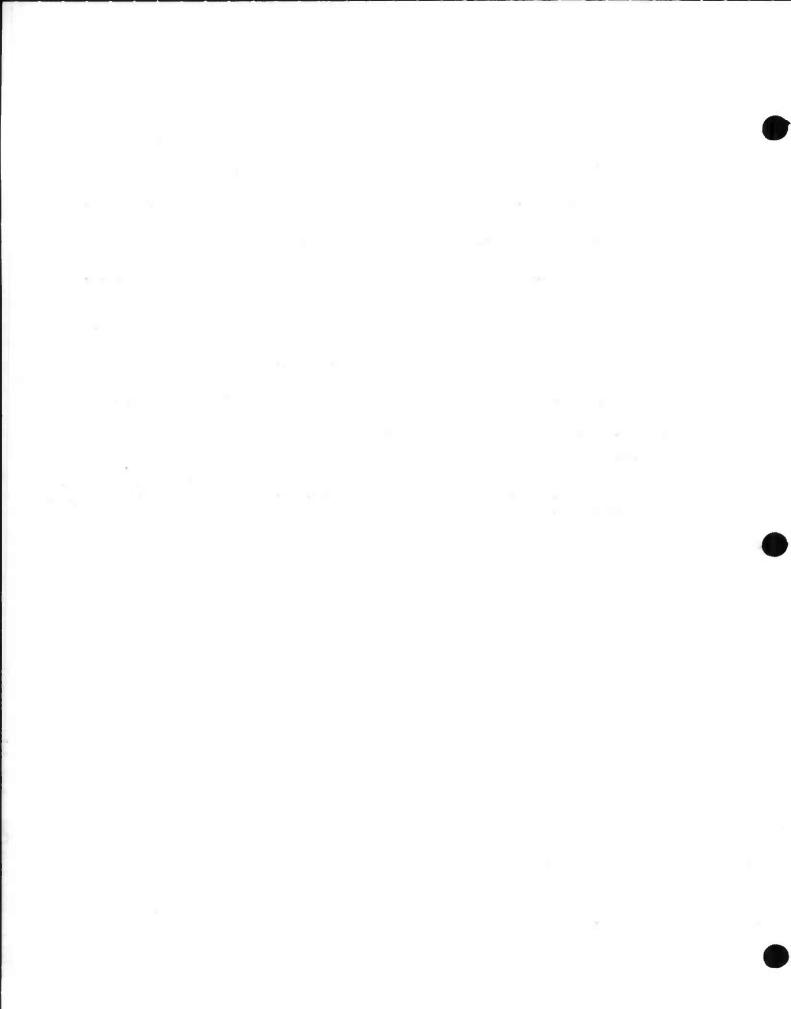
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	OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may b	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page hours after death with the State have of Health and Mental Horlings prior to build cremation or removal	item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be
	_	0 2	- 2

1. DECEDENT'S NAME (First, Middle, Last) 11, 2. DATE OF DEATH 3. TIME OF DEATH Matthew Allen Thompson March 1993 11:15 PM M 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign HOURS 1 💢 M 2 🗌 F 218-58-1672 42 YRS. 11,1951 Wash. January 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH FUNERAL DIRECTOR 2919 November Ct. Bowie Prince George's RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Prince George's Silver Hill 1 YES 2 NO 10e. STREET AND NUMBER 10f. ZIP COOE 10g. CITIZEN OF WHAT COUNTRY? 4000 Belnor Lane 20746 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 THO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yea, specify Cuban, Mexican, Puarto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 XXever Married 2 Married B Specify: 3 Widowed 4 Divorced Caucasian COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11th N/A Interior Decorator Self-employed 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) George Edward Thompson Margaret Theresa Flaherty BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Margaret Thompson Same as 10 A-F 20a. METHOD OF DISPOSITION

1 Surial 2 XXXX matter 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE cemetery, crematory or other piece, Clinton, Maryland 3 - 16 - 9321. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd Clinton, Md I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate ahock, or haart failure. List only one cause on each line. Interval Betwe **IMMEDIATE CAUSE (Final Onset and Death** sophageal (nacosa disease or condition DSON 110 resulting in death) DUE TO (OR AS A CONSEQUENCE OF): BY PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF GAUSE dal MOMISSI 47 T | YES 2 | NO OF DEATH? T TES 2 NO 15. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINENT HOSPITAL: OTHER: 1 C Inpatient 2 C ER/Outpatie a [] DOA ng Home 5 Residence 5 - Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Disp. Year) 28c. INJURY AT WORK? 284. DESCRIBE HOW INJURY OCCURED 1 Scherund 5 Pending 1 YES 2 NO 2 Accident 3 🔲 Swicide 28e. PLACE OF INJURY -- At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Flurid Floute Number Olly of Revo. State) COMPLETED 4 | Homicide TY CERTIFYING PHYBICIAN To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) ation and/or investigation, in my opinion, death 29d. OATE SIGNEO (Modifin, Day, Year) BE Muc 18754 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Princ) 7525 Greenway Ctr. Drive #205 Brensinger MD Greenbelt, Maryland 20770 32. REGISTRAR'S SIGNATURE LINE Day doon Randalle

HOSPITAL



## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

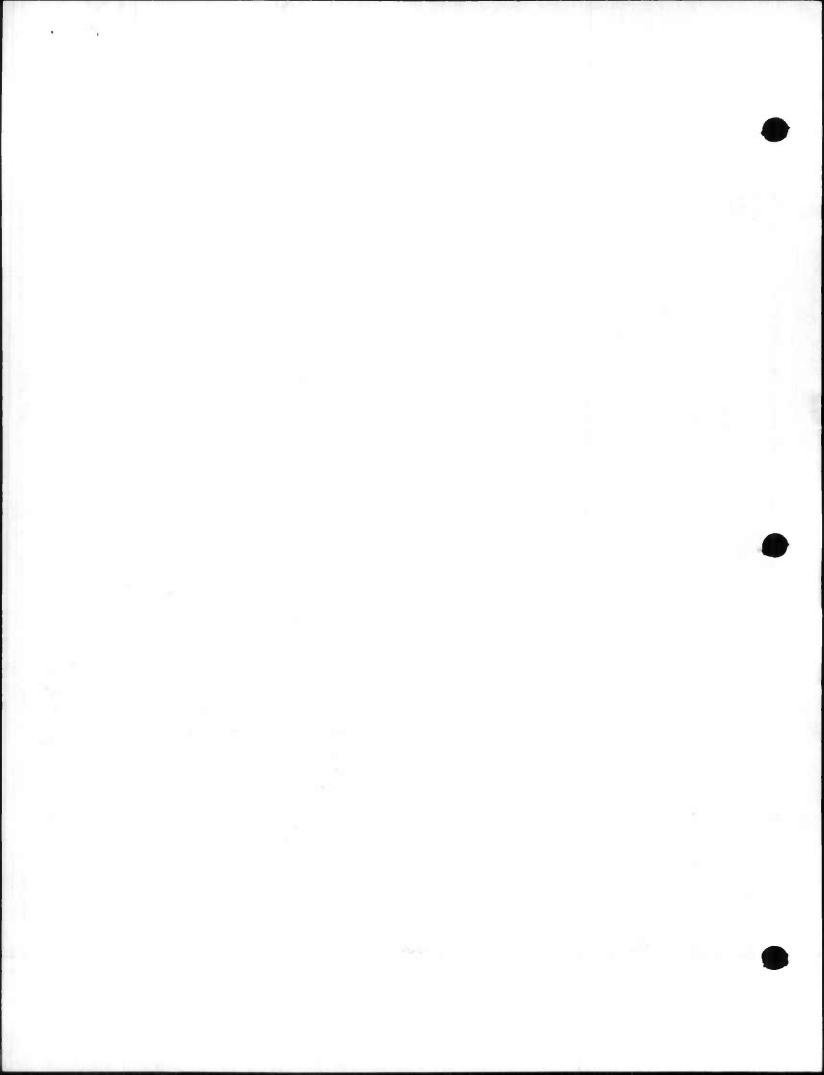
	1 - FOR STATE REGISTRAR	STATE OF MARYLA		ENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIENE REG. NO.	E			
- 1	1. DECEOENT'S NAME (First, Middle, Lest)  ROGER Washi	ington	TYLER		2. DATE OF DEATH MONTH DAY MARCH 1	, 1993	3. TIME OF DEATH 3:40 A. M		
	220-34-7173	1 ⊠ M 2 □ F 5	2 YRS.	JADER 1 YEAR IF UNDER 24 HRS. THIS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 6/14/1940				
TOR	98. FACILITY NAME (If not institution, give street  2062 Harlequin Ter  RESIDENCE OF DECEDENT			CITY, TOWN OR LOCATION OF E LIVER Spring	DEATH	Montg			
DIRECTOR	10a. STATE 10b. COUNTY	derick		WN OR LOCATION  AUTY			10d. INSIDE CITY LIMITS? 1 YES 2 NO		
FUNERAL	100. STREET AND NUMBER 4948 Westwind Driv			101. ZIP CODE 21771		10g. CITIZEN OF WHAT COUNTRY? USA			
B⊀	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 XX(4D	13. WAS OECENDENT OF HISPA If yes, specify Cuban, Maxic 1 YES 2 NO Speci	en, Puerto Rican, etc.)	os or No—  14. RACE — American Indian, Black, White, etc.  Specify: Black			
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade cor Elementary/Secondary (0-12)	mpleted) Coflege (1-4 or 5+)	16a. DECEDENT'S USU (Give kind of work We. Do NOT use red asphalt w	done during most of working led.)	166. KIND OF BUS	iness/industry  t/blackt	i an		
	17. FATHER'S NAME (First, Middle, Last) George Washington		18. MOTHER'S N	AME (First, Middle, Maiden s		.ор			
TO BE	19a. INFORMANT'S NAME (Typo-Print)  Porothy Thomas		PRESS (Street and Number or Rural er Apts., Free	I Route Number, City or Town					
	20a. METHOD OF DISPOSITION  1 C Buriet 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. PLACE AND DATE OF DISPOSITION (Name of cornelary, crematory or other place)  Resthaven Memorial Gardens 3/6/93 Frederick								
	21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE Demm	er)	22. NAME AND ADDRESS OF F Stauffer Fund Frederick, Mo	ACILITY				
	23. PART I. Enter the diseases, or con ehock, or heert failure. Lis	nplications that caused st only one cause on ea	the deeth. Do not o				Approximate interval Between		
	iMMEDIATE CAUSE (Fine) disease or condition						Onset and Death		
N	disease or condition resulting in death)	Stree	CONSEDUENCE OF):	canen			Onset and Death		
FICATION	Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (DR AS A DUE TO (OR AS A LA DAY NOV	CONSEQUENCE OF):  THE CA	c ancom			Onset and Death		
CERTIFICATION	Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	DUE TO (DR AS A LA TA) NOVA DUE TO (DR AS A LA TA) DUE TO (DR AS A LA TA)	CONSEQUENCE OF):  CONSEQUENCE OF):  CONSEQUENCE OF):	NCEN			Onset and Death		
AL	Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (DR AS A LA TA) NOVA DUE TO (DR AS A LA TA) DUE TO (DR AS A LA TA)	CONSEQUENCE OF):  CONSEQUENCE OF):  CONSEQUENCE OF):	NCEN	n Part I. 24a. WAS AN. PERFORI 1   YES 2	MEO?	Onset and Death  ( () ) )  WERE AUTOPSY FINDINGS  AMALABLE PRIOR TO  COMPLETION OF CAUSE  OF DEATH?		
AL	Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST  PART II. Other aignificant conditions of the cause of the	DUE TO (DR AS A LA TA) NOVA DUE TO (DR AS A LA TA) DUE TO (DR AS A LA TA)	CONSEQUENCE OF):  CONSEQUENCE OF):  CONSEQUENCE OF):	NCEN	PERFORI	MEO?	Onset and Death  ( () ) )  WERE AUTOPSY FINDINGS  AMALABLE PRIOR TO  COMPLETION OF CAUSE		
AL	Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST  PART II. Other aignificant conditions of the cause in the cause of the	DUE TO (DR AS A LA TA) NOVA DUE TO (DR AS A LA TA) DUE TO (DR AS A LA TA)	CONSEQUENCE OF):  12 PC CASEQUENCE OF):  12 It not resulting in the state of the st	26. PLACE OF DEATH (C) HER: Nursing Home 5  Residence	PERFORI 1 YES 2	MEO?	Onset and Death  ( () ) )  WERE AUTOPSY FINDINGS  AMALABLE PRIOR TO  COMPLETION OF CAUSE  OF DEATH?		
BY PHYSICIAN: MEDICAL	Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST  PART II. Other algnificant conditions of the cause of the	DUE TO (DR AS A LA TO	CONSEQUENCE OF):  CONSEQUENCE OF):  It not resulting in the state of t	26. PLACE OF DEATH (C HER: Nursing Home 5   Residence 28c. INJURY AT WORK? 1   YES 2   NO	PERFORM  1 YES 2  Theck only one)  8 Other (Specify)  28d. DESCRIBE HOW IN	MEO?	Onset and Death  ( () ) )  WERE AUTOPSY FINDINGS  AMALABLE PRIOR TO  COMPLETION OF CAUSE  OF DEATH?  1 YES 2 ND		
BY PHYSICIAN: MEDICAL	Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST  PART II. Other algnificant conditions of the cause in the cause of injury that initiated events resulting in deeth) LAST  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	DUE TO (DR AS A OF INJURY (Month, Day, Year)	CONSEQUENCE OF):  CONSEQUENCE OF):  It not resulting in the street of th	26. PLACE OF DEATH (COMPANY AT WORK?  MER:  28. PLACE OF DEATH (COMPANY AT WORK?  M 1 YES 2 NO  1, factory, office	PERFORI  1 YES 2  Theck only one)  8 Other (Specify)  28d. DESCRIBE HOW IN  281. LOCATION (Street a: City or Town, State)	MEO?  NO  NO  NO  NO  NUMBER OF Rural I	Onset and Death  ( () ) )  WERE AUTOPSY FINDINGS  AMALABLE PRIOR TO  COMPLETION OF CAUSE  OF DEATH?  1 YES 2 ND		
BY PHYSICIAN: MEDICAL	Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST  PART II. Other aignificant conditions of the cause in the cause of injury that initiated events resulting in deeth) LAST  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	DUE TO (DR AS A INTERPRETATION OF THE PROPERTY	CONSEQUENCE OF):  CONSEQUENCE OF):  It not resulting in the street of th	26. PLACE OF DEATH (C HER: Nursing Home 5   Residence 28c. INJURY AT WORK? 1   YES 2   NO	PERFORM  1 YES 2  Theck only one)  8 Other (Specify)  28d. DESCRIBE HOW IN  281. LOCATION (Street as City or Town, State)	MEO?  NO  NO  NO  NO  NO  NO  NO  NO  NO	Onset and Desth  ( () ) )  WERE AUTOPSY FINDINGS  AMALABLE PRIOR TO  COMPLETION OF CAUSE OF DEATH?  1  YES 2 ND  Route Number,		
AL	Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST  PART II. Other aignificant conditions of the cause in the cause of injury that initiated events resulting in deeth) LAST  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	DUE TO (DR AS A INTERPRETATION OF THE BUILDING TO CONTRIBUTING TO GENERAL STATE OF INJURY (Month, Day, Year)  28e. PLACE OF INJURY (Month, Day, Year)  28e. PLACE OF INJURY (Month, Day, Year)  28e. PLACE OF INJURY (Month, Day, Year)  AN: To the best of my knowled on the best of axamination	CONSEQUENCE OF):  THE CONSEQUENCE OF):  It not resulting in the consequence of the conseq	26. PLACE OF DEATH (COMMENT)  WORKY  M 1 YES 2 NO  The time, data and place, end du my opinion, death occured at the	PERFORM  1 YES 2  Thock only one)  8 Other (Specify)  28d. DESCRIBE HOW IN  281. LOCATION (Street as City or Town, State)  te to the cause(a) and mane it lims, date and place, and	MEO?  NO  NO  NO  NO  NO  NO  NO  NO  NO	Onset and Desth  ( () ) )  WERE AUTOPSY FINDINGS  AMALABLE PRIOR TO  COMPLETION OF CAUSE OF DEATH?  1  YES 2 ND  Route Number,		



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the law requires that the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MAR 2 2 1993 Julie xundson-Randsee



09536 93

1	FOR STATE REGISTRAR	STATE OF MA					EALTH AND DEATH	MENTA	L HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Lost) AUDREY LORR		TURNER							3. TIME OF DEATH 11:48 P M		
ı	4. SOCIAL SECURITY NUMBER 216-96-6951	1 🗆 M 2 🔀 F	1 M 2 XF 27 YRS. MONTHS DAYS HOURS MIN. MAY 18 MIN. MAY 18 MIN.				OF BIRTH	.965 September 2015		)_		
	9a. FACILITY NAME (If not institution, give a THE JOHNS HOPKI RESIDENCE OF DECEDENT	AL				IMORE	EATH		BAL7		RE CITY	
	10a. STATE 10b. COUNT	rford	10c. CITY, TOWN OR LOCATION Bel Air					LIMITS?			10d. INSIDE CITY LIMITS? 1 YES 2 X NO	
	512 S. Tollgate I	101. ZIP CODE 21014					10g. CITIZEN OF WHAT COUNTRY? USA					
	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT FORCES? 1 [ IF YES, GIVE WA	YES 2	YES 2 10 If yes, specify Cuben, Mexico			an, Puerto Rican, etc.)			Black.	- American Indian, White, atc.	
	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	- f	(Give kind of work done during most of working life. Do NOT use retired.)				siness/industry urance					
7 10	17. FATHER'S NAME (First, Middle, Last) Thomas David	White		18. MOTHER'S NAME (First, Middle, Melden Sharon —					Surname) Thomas			
	190. INFORMANT'S NAME (Type/Print) Craig L. Turner						nd Number or Aural te Road					4
	20e. METHOD OF DISPOSITION  1 ☐ Burlel 2 1 Cremation 3 ☐ Rem  1 ☐ Donation 5 ☐ Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE U		20b. PLACE cemetery C R. A	rematory or of Fer		rem	atory 3			ation – c		vn, Stata r, Pa.
	23. PART I. Enter the diseases, or	< me C	oma	12 12	How 131	ard 7 C	okesbury	omas 7 Roa	ad, Abi	ngdor	n. Mo	me, P.A. d. 21009
	interval Bet immediate CAUSE (Final disease or condition resulting in death)  Sequentially liet conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  Interval Bet Onset and in the cause of the c									Onset and Death 48 Hay 4 YEAR		
	PART il. Other significent conditions contributing to death but not				In the und	ertying	cause given in	Part I.	24a. WAS AN PERFOR	MED?		WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NOT
	25. WAS CASE REFERREO TO MEDICAL 26. PLACE OF DEATH (Check only one)  HOSPITAL: OTHER:											
	1 VES 2 NO  27. MANNER OF DEATH  Netural 5 Pending	1 Nonetiant 2   1 26a. DATE OF IP (Month, Day	JURY	26b. TIM		8c. INJ	JRY AT RK?	aaldenca 8 Other (Specify)  26d. DE\$CRIBE HOW INJURY			RY OCCURED	
	2 Accident Investigation 3 Suicide 6 Could not be determined	nome, farm, s	1 1 123 2 1 NO				t and Number or Rural Route Number, e)					
	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYS	ICIAN: To the bast of m										and manner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIE	A					29c. LICENSE NUI					(Month, Day, Year)
	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE	OF DEATH (IT	EM 27) (Type,		8	E MA	Dis	n.	13Az	IIN	JORF MID
	31. DATE FILEO (Month, Day, Year) MAR 22'93	32. JEGISTRAB	SIGNATURE	Pandalle							7 1	

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dSd.

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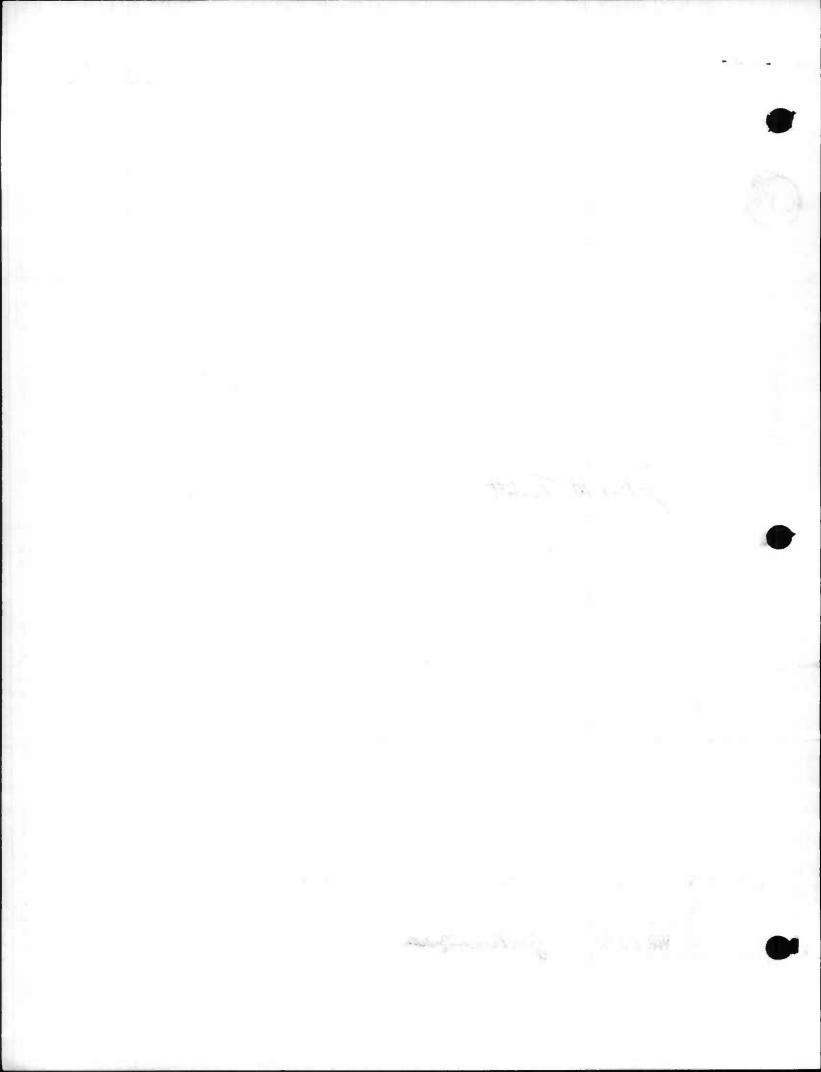
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

-	1000	100	
BALTIMORE, MARYLAND 21215-0020	ours after death. Page 6 may be retained by the hospital or attending physician.	d in by the funeral director, page 5 should be detached for use as the burial-transit perm or removal.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Plus filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burlat, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

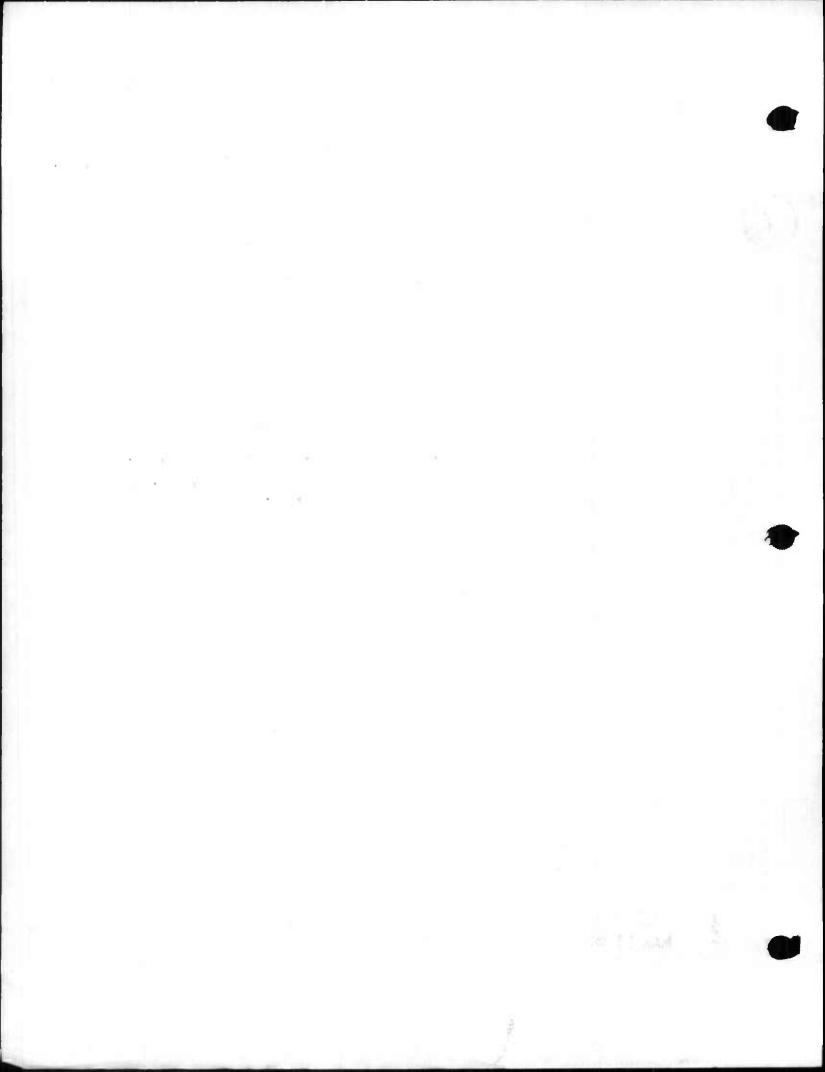
1 -	FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL CERTIFICATE OF DEATH	HYGIENE REG. NO.

nedio i nan		CERTIFIC	AIE	PUEAIR		REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last)  ERVIN R. TAYLO	R				2. DATE MONT	OF DEATH DA	, 190	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER 5. St 213-16-9588T 1X	6. AGE (1)		F UNDER 1 YEAR		7. DATE (Mont)	OF BIRTH		BIRTHPLACE (State or Foreign Country)
9a. FACILITY NAME (If not institution, give street ar	O A D		HITE	N OR LOCATION OF E		2702	9c. COUNT	Y OF DEATH
RESIDENCE OF DECEDENT	UND	- N	11111	FUKD			HARI	UKD
0a. STATE 10b. COUNTY	RFORD		TOWN OR LO					10d. INSIDE CITY LIMITS? 1 YES 2 XXO
1440 PROSPECT R	OAD			101. ZIP CODE 21160			USA	EN OF WHAT COUNTRY?
1 Never Married 2 Married	MAS DECEDENT EVER IN FORCES? 1 YES FYES, GIVE WAR OR DA	2. NO	If yes	DECENDENT OF HISPA specify Cuban, Maxie (ES 2 70 NO Speci	ean, Puerto	N? (Specify Yes Rican, etc.)	or No- 1	4. RACE — American Indian, Black, White, etc.
15. DECEDENT'S EDUCATION (Specify only highest grade complete)	eted)	16e. DECEDENT'S US (Give kind of work life. Do NOT use n	k done during	ATION most of working	16b	. KIND OF BUS	INESS/INDU	STRY
Elementary/Secondary (0-12) Coll	lege (1-4 or 5 +)	CIVILS		CE	G	OVERNI	MENT	
7. FATHER'S NAME (First, Middle, Last) REUBEN TAYLOR				18. MOTHER'S N	AME (First,	Middle, Meiden DER	Surname)	
GLADYS I. JONES		PO Box	DRESS (Stre	et and Number or Rura DELTA	, PA	ber, City or Town	State, Zip C	Code)
Buriel 2 Cremetion 3 Removal to	rom State 20b	PLACE AND DATE OF I	DISPOSITION		DAT	E 20c, LOC	CATION - CI	ty or Town, State A , PA . 17314
n. SIGNATURE OF FUNERAL SERVICE LICENSE		ATE NIDO	22. NAME	AND ADDRESS OF F	ACILITY			NC., DELTA,P
Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that initiated events reaulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):  CONSEQUENCE OF):			-			7 YEAR
ART II. Other significant conditions con	ntributing to deeth b	ut not resulting in t	the underly	/ing ceuse given l	n Part I.	24s. WAS AN PERFORE	MED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF OEATH?  1  YES 2 NO
S. WAS CASE REFERRED TO MEDICAL			28	. PLACE OF DEATH (C	heck only or	10)		1
	SPITAL: Inpetient 2 - ER/Outp		THER:					
	28a. DATE OF INJURY	28b. TIME O		INJURY AT	-	SCRIBE HOW IN	HIEV COC	DED
1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUR	Y	WORK?	200. DE:	SCHIBE HOW IF	JUNY OCCU	NEU
3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE OF INJURY building, etc. (Spec	— At home, farm, stre	et, factory, o	ffica	26f. LOC C/fy	ATION (Street a or Town, State)	nd Number or	Rural Route Number,
9a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: 0 MEDICAL EXAMINER: On								
	the deals of explimitation	and/or investigation, i	птину орино	n, death occurso at th	e time, data	and placa, and	dua to the	cause(s) and manner as stated.
96. SIGNATURE AND TITLE OF CERTIFIER	250	LB 43		M) O	JMBER 3581	3-6	29d. DATE	SIGNED (Month, Day, Year)  ARCH 19 19 93.
O. NAME AND ADDRESS OF PERSON WHO COM	SUITE	ATH (ITEM 27) (Type, Pri	APFIC	HILL ME	) CFA	TER 25	MONU	ARCH 19 1993. MENT RD, YORK 1
LAND 3 03	32. REGISTRAR'S SIGN	NI ONE	Tirre					, , , , , ,



DALL MAN LAND	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filled within 72 hours after death with the State Deat, of Health and Mental Hydiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	
	hours after death.	d in by the funeral	medical exami	
,00,00	acuted within 24 n	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f be filled within 72 hours after death with the State Deat, of Health and Mental Hyglene prior to burial, cremation, or removal.	atic event, the	
60.00	th certificate be ex	lending physician and Hyglene prior to	or other traum	
5000	uires that the dear	signed by the att	ws any Injury,	
	IAN: The law requ	tificate has been e State Dept. of I	or Hern 23 sho	
	<b>TENDING PHYSICI</b>	OR: After this cert fter death with the	8 Is marked, o	
	OSPITAL OR ATT	UNERAL DIRECTI tithin 72 hours at	ANT: If Item 2	
	THE H	TO THE F	IMPORT	

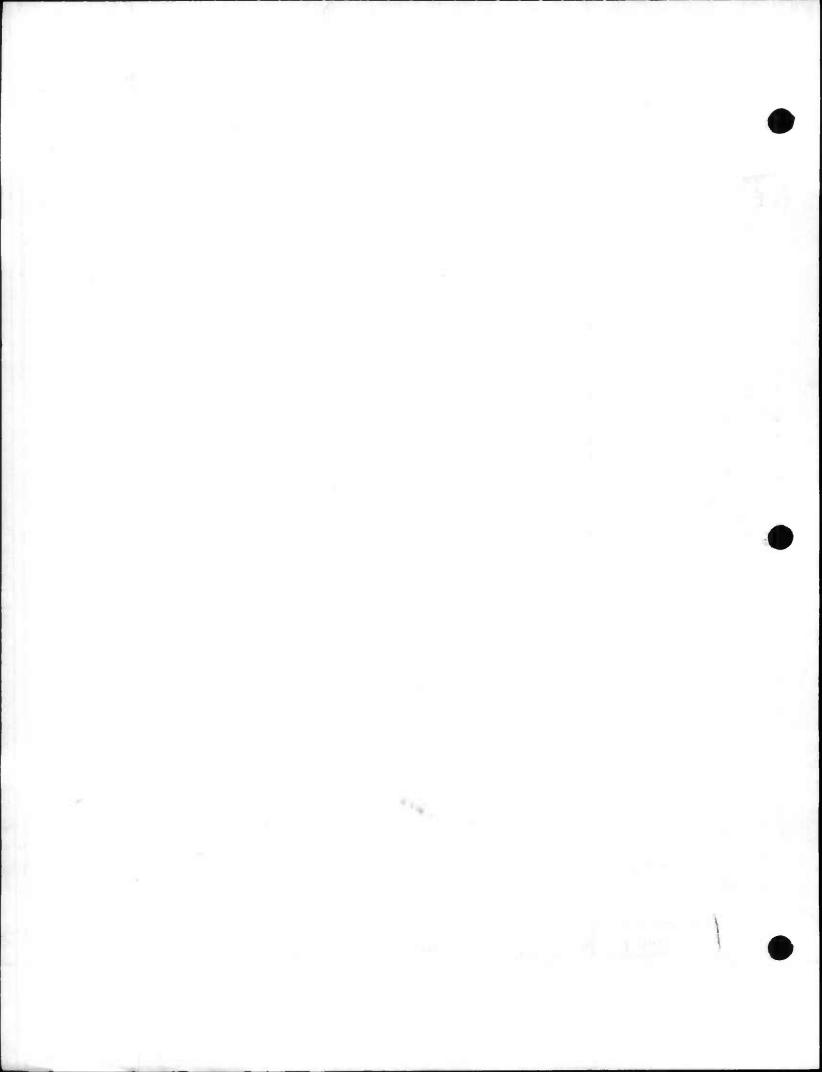
	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFICA	ENT OF H	EALTH AND I	MENTAL HYGIE	_	93 09538
	DECEDENT'S NAME (First, Middle, Last)     SOCIAL SECURITY NUMBER	ALICE		UNDER 1 YEAR	F UNDER 34 HRS.	2. DATE OF BEATH MONTH  7. DATE OF BIRTH APRIL 30	5 9:	3. TIME OF DEATH    2 40 p M  BIRTHPLACE (State or Foreign  NEWARK, MD.
CTOR	90. FACILITY NAME (If not institution, give a Renal Trea		00	CITY, TOWN O	PR LOCATION OF DE		9c. COUNTY	
L DIRECTOR		WORCESTE		OWN OR LOCAT	VEWAR	'K		10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	10e. STREET AND NUMBER	Box 5 / 2 /8	4 ADMOS		2/84			N OF WHAT COUNTRY?
B⊀	1 Never Married 2 Married 3 Widowed 4 Diverced	FORCES? 1 YES	2 ØNO ATES	If yes, spe	2 NO Specify	tiĆ ORIGIN? (Specify Yi n, Puerlo Rican, atc.) /:	14.	Black, White, atc.  Specify: BLACK
COMPLETED	16. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		16a. DECEDENT'S USUA (Give kind of work of life. Do NOT use reti DOMESTI	done during mos tired.)	N st of working	HOUSEW		TRY
BE CO		HOLLAND			LOTTI	ME (First, Middle, Maide [E TIMMONS	5	
2	190. INFORMANT'S NAME (Type/Print) HARRISON TIND 200. METHOD OF DISPOSITION		ADDRES	S SAME	AS ABOV			
	1\(\) Burlet 2 Cremetton 3 \(\) Rem 4 Donation 5 \(\) Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LICE	noval from State capy	PLACE AND DATE OF DIS	PURCH C	CEM.	3-13 NEW	IARK, MI	D.
	- Loute &	, Joelen		SALISB	BURY, MD.	21801		2, BOX 920
NOI	immediate Cause (Final disease or condition reaulting in death)  Sequentially list conditions,	a. Oue TO (OR AS A	I the death. Do not each line.  CONSCIPLINE.  CONSCIPLINE OF:	ner the mod	se of dying, auch	n as cerdiac or resp	iratory arrest	t, Approximata interval Between Onset and Death
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. DUE TO (OR AS A	CONSEQUENCE OF):		<i>(</i> -			
PHYSICIAN: MEDICAL C	PART II. Other algnificent condition	a contributing to death bu	it net resulting in the	a underlying	cause given in i		PAMED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2 NO
SICIAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☑ YES 2 ☐ NO	HOSPITAL: 1   Inpatient 2   ER/Outpe		HER:	ACE OF DEATH (Che		n'alua	1. X
ВУ РНУ	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	26e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	M 1 Y	JRY AT RK? ES 2 NO	28d. DESCRIBE HOW	INJURY OCCUR	ED // //
	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY building, etc. (Specif	пу)			261. LOCATION (Street City or Town, State	»)	Rural Route Number,
COMPLETED		ER: On the best of my knowle						euse(s) and menner ee stated.
O BE	29b. SIGNATURE AND TITLE OF CERTIFIER  Some	B J.	/hann	A	29c. LICENSE NUM	20050	29d. DATE SI	GNED (MUIT), Day, Year)
	30. NAME AND ADDRESS OF PERSON WHO	S. CHA	TH (ITEM 27) (Type, Print)	7-0	Rivers	wich De	. Sá	h.h. 1102/2
0	31. DATE FILED (MODIT) DO 1993	Julia Jau'ld Son-	IHRARA.				(	



	1 - FOR STATE REGISTRAR	STATE OF I					HEALTH A		NTAL HYGIEN	40	3	09539
8	1. DECEOENT'S NAME (First, Middle, Last)  Mary	н.		Taylo	r			2	DATE OF DEATH MONTH	<sup>DAY</sup> 7	year 3.	TIME OF DEATH 6:15 am
4	4. SOCIAL SECURITY NUMBER  222-14-5871  9a. FACILITY NAME (If not Institution, give st	5. SEX 1  M 2  F	8. AGE (In yrs. les	57 YRS.	MONTHS		MIN.	DATE OF BIRTH (Month, Day, Year) 2-25-26		Country)	ICE (State or Foreign	
DIRECTOR	Berlin Nursing					y, town	OR LOCATION	N OF OEATI	<b>Y</b>		TY OF DEATI	
L DIRE	MD Wi CO			v, тоwn uit1						1 [	1. INSIDE CITY LIMITS? YES 2 NO	
ETED BY FUNERAL	P O Box 656/305  11. MARITAL STATUS  1 Never Merried 2 Merried  3 Midowed 4 Divorced  15. DECEOENT'S EQU. (Specify only highest grade  Elementary/Secondary (0f(2))	12. WAS OECEDEN FORCES? 1 IF YES, GIVE N	TEVER IN U.S. AF	RMEO NO ECEOENT'S	USUAL (	. WAS OEG	CENOENT OF pecify Cuban 3 2 X NO	NISPANIC (Maxican, P	ORIGIN? (Specify Ye userto Rican, etc.)	s or No-	14. RACE — Black, Wi Specify: Black	S. American Indian, hita, atc.
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	College (1-4 or 5	*)	1	9Lm		JEKK 18. MOTHE	ER'S NAME	(First, Middle, Malder	Surname)		-
TO BE	19e. INFORMANT'S NAME (Type/Print)  MARY LL 8	Shoul	JR 19	b. MAILING	ADDRES	SS (Street	and Number of	A Pural Pour	eyNumber, City or Tov	vn. State, Zip (	gode)	4 ml
	20a. METNOD OF OISPOSITION 1 Duriel 2 Cremation 3 Remote 4 Donation 5 Other (Specify)		20b. PLACE	ANO OATE OF OUR	har plant	11	mater	4	OATE 20c. LC	CATION - C		State Md.
3	21. SIGNATURE OF PUHERAL SERVICE LIC	Folls		1	P	. 0.	BOX	1574/	917 W. I	sabel	la St.	. Salis, M
	23. PART I. Enter the diseasea, or c shock, or heart felture. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	Lat only one ceu	t coused the deuse on each line  (OR AS A CONSE	RCIA	ot ente	r the mo	ode of dyln	ig, auch e	a cerdiec or reap	Iratory erre	et,	Approximate Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		(OR AS A CONSEC									
PHYSICIAN: MEDICAL CEF	PART II. Other algnificant conditions  Sent (12		death but not r		n the u	nderiyin	g couse gl	ven in Par	1 L 24B. WAS AN PERFOI	RMED?	COA OF I	RE AUTOPSY FINDINGS ILABLE PRIOR TO MPLETION OF CAUSE DEATH?  YES 2 NO
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHE	R:	ACE OF OE					
ву РНУ	27. MANNER OF OEATH  1 Natural 5 Pending 2 Accident Investigation	28e. OATE OF	Inpetient 2						Other (Specify)  28d. OESCRIBE HOW INJURY OCCUREO			
	3 Suicide 6 Could not be determined	building,	FINJURY — At ho etc. (Specify)						I. LOCATION (Street City or Town, State)			Number,
COMPLETED	29a. CERTIFIER (Check only one)  1 CERTIFYING PNYSIC DESCRIPTION ON DESCRIPTION OF THE CERTIFYING PNYSIC DESCRIPTION OF THE CERTIFICATION O	EIAN: To the best of	my knowledge, de kemination and/or i	ath occurre	d at the	time, deta	and place, a	and due to t	he cause(a) and ma o, data and placa, ar	nner as stated	f. cause(s) and	manner as stated.
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER  30. NAME AND ADDRESS OF PERSON WHO	COMPLETED	$\sim$					2026		L	SIGNED (Mor	7th, Day. Year)

Frddrico Arthes, 1622A Ocean Pines, Berlin Md. 21811 32. REGISTRAR'S SIGNATURE Davidson

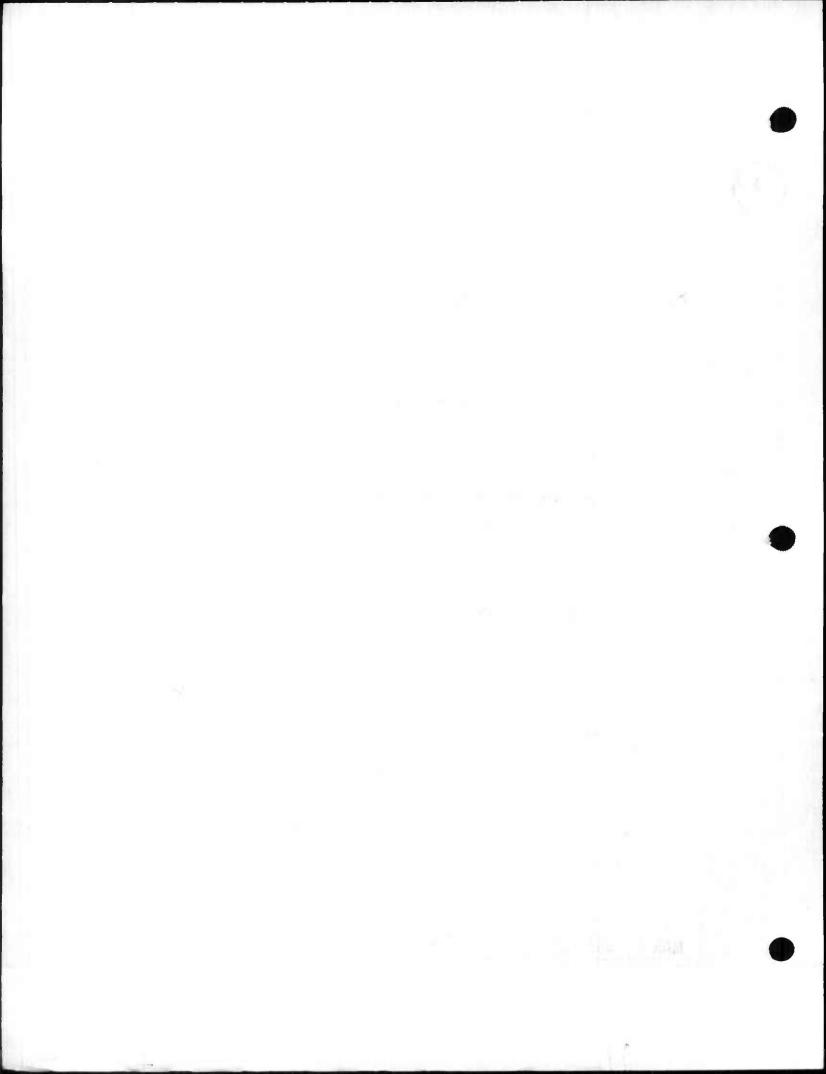
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF ORATH (ITEM 27) (Type, Print)



BALTIMORE, MARYLAND 21215-0020

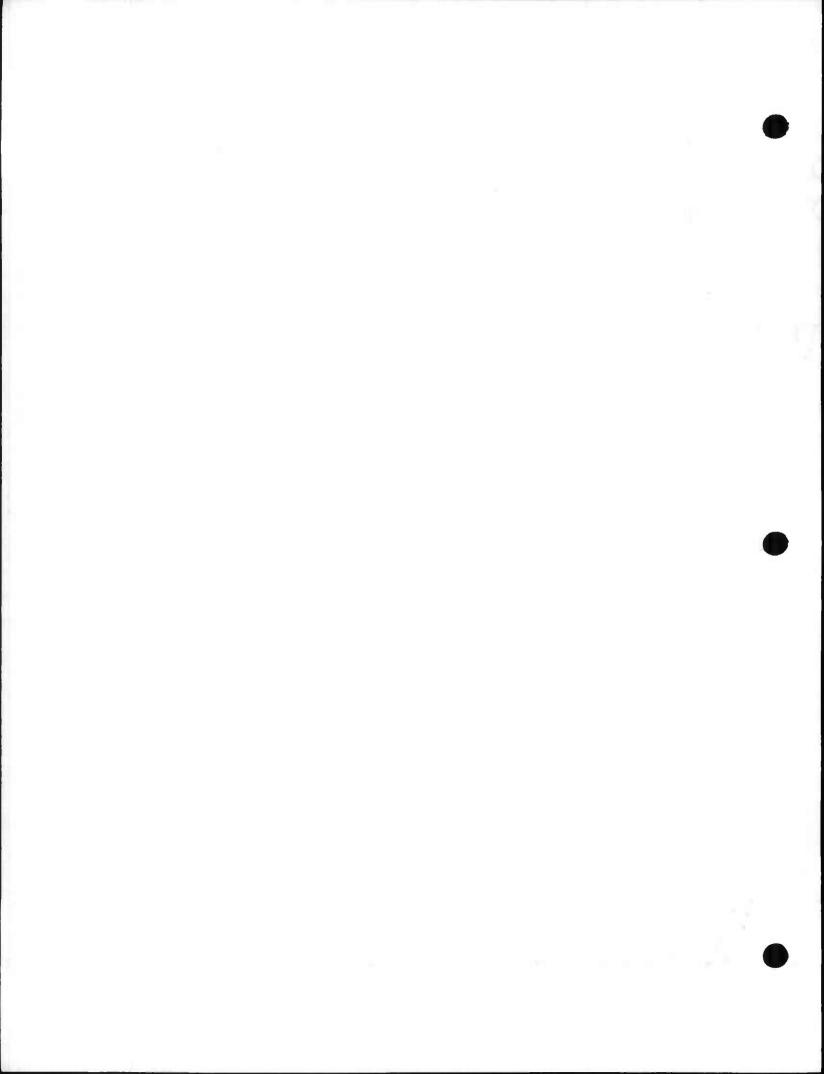
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR			CERTIF	ICALE	: UF	DEATH	R	EG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last) The 1ma		Tat	ıstin			-	2. DATE OF D MONTH	DAY 12	YEAR 93	3. TIME OF DEATH 1:00 a M
	4. SOCIAL SECURITY NUMBER	5. 9EX	6. AGE (in yrs	lest birthday)	IF UNDER	1 YEAR	IF UNDER 24 HRS.	7. DATE OF B			HPLACE (State or Foreign
	112-05-0175	1 🗌 M 2 🔯 F	90	YRS.	MONTHS	DAYS	HOURS MIN.	(Month, Day 02/ 1	( Vear)	Count	
	9e. FACILITY NAME (If not institution, give str	reet end number)	90		9b, CITY	TOWN C	R LOCATION OF D			COUNTY OF D	
Œ	Berlin Nursing	Home					lin			orcest	
DIRECTOR	RESIDENCE OF DECEDENT	поше				Del	1111		- ''	Orcest	
H.	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN O	R LOCAT	ION				10d. INSIDE CITY
5	Maryland W	orcester		0	cean	Cit	У				LIMITS?
AL	10s. STREET AND NUMBER			101	ZIP CODE		100	. CITIZEN OF	WHAT COUNTRY?		
FUNERAL	2301 Philadelphia	a Ave.					2184	42		USA	
5	11. MARITAL STATUS	12. WAS DECEDEN			13. \	MAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Sp	ecify Yes or N	0— 14. RAC	E — Americen Indian, k, White, etc.
ВУР	Never Married 2  Married 3  Widowed 4 Divorced	FORCES? 1 IF YES, GIVE W		Z NO			2 NO Specific		, atc.)	Spec	ity:
	15. DECEDENT'S EDUC		16a.	DECEDENT'S	USUAL OC	CUPATIO	IN .	16h KINI	OF BUSINES		hite
COMPLETED	(Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4 or 5 +	,	(Give kind of a life, Do NOT us	work done done done retired.)	furing mo:	st of working	1000 1000	o, boome	O/1110001111	
립		Conego (1-4 ch 3 4	<b>'</b>	homem	aker						
8	17. FATHER'S NAME (First, Middle, Last)					_	18. MOTHER'S NA	MF (First Middle	Maiden Suma	mel	
	Issac (unk) Taus	tin						(unk)		-,	
BE	19e. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS	(Street o	nd Number or Rural				
임	Sam D. Taustin						idge Rd				21842
	20a. METHOD OF DISPOSITION		20h. Pl. Ai	CEAND DATE						N — City or To	
	1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo	val from State	cemetery.	crematory or o	ther place)		erv	1			MD. 21801
	21. SIGNATURE OF FUNERAL SERVICE LICE	mjer //	1 Dec	11 1516	22.1	NAME AN	D ADDRESS OF FA	CILITY		buly,	IID. 21001
	200 M. Ho	ellow	an				way Fundance Hil			nrv. M	id. 21801
	23, BART I. Enter the diseases, or co	omplications that	caused the	death. Do r	not entar	the mo	de of dying, auc	h aa cardiec	or respirator	v arrest.	Approximate
9	snock, or neert failure. L	ist only one cau	e on each i	ina.							Interval Between Onset and Death
	disease or condition	DUE TO	ntel	rpl	P	111	UMO	1750	7		3 day
	resulting in death)	DUE TO	OR AS A CON	SEQUENCE O					*		
Z		CA	RAID	> Ph	o hi	M	In m	V P	1601	16	İ
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	OR AS A CON	SEQUENCE OF	F):		1				
5	CAUSE (Disease or Injury	121	ate	nib!	10	1-0	rosis				
E	that initiated events	DUE TO	OR AS A CON	SEQUENCE OF	F):						
EH	resulting in death) LAST										
	PART II. Other significant conditions	contributing to	death but no	of resulting	in the un	derlylog	cours alves la	Port I DI	WAS AN AUTO		
EDICAL	1-115/2	min		n.,	o pers	aerrynig 	Cadse given ig	Part I. 248.	PERFORMED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
ā	100	min	- /.	7/17	7	7		10	YES 2	0	COMPLETION OF CAUSE DF DEATH?
Σ	/			101	40	-	Z	_			1 - YES 2 - NO
A	25. WAS CASE REFERRED TO MEDICAL	1 119.	260	200							
Ö	EXAMINER?	HOSPITAL:			OTHER		ACE OF DEATH (Ch	eck only one)			
PHYSICIAN:	1 YES 2 NO	1 Inpatient 2 I		_			5 🗆 Residence				
	1 Natural 5 Pending	(Month, De		26b. TIM	URY M	28c. INJU WOI	RK?	26d. DESCRIB	E HOW INJURY	OCCURED	
B	2 Accident Investigation 3 Suicide & Could and be	28e. PLACE OF	IN HIDY At	home larm a			ES 2 NO				
	4 Homicide 6 Could not be	building, a	rtc. (Specify)	rionne, term, t	Areet, IECTO	ну, описе		261. LOCATION City or Tow	(Street end Nu n, Stete)	imber or Rural F	Route Number,
<u>u</u>	290. CERTIFIER		_								
4	(Check only										
COMPLET	2 MEDICAL EXAMINER	On the beele of ex	amination end/	or investigation	n, in my of	olnion, de	with occured at the	time, date end p	place, and due	to the ceuse(s	e) and menner se stated.
BE (	296. SIGNATURE AND TITLE OF CERTIFIER	L.					29c. LICENSE NUI	MBER			(Month, Day, Year)
2	1200-	m	n				D0202	2.6		3-1	243
-	30. NAME AND ADDRESS OF PERSON WHO										
/	Federico 6. Art				ean I	ine	s, Berli	n, MD	21811		
6	31. DATE FILED (MORE), Day, Year) MAR 16 1993	la Davidson	- Jande	ee.							

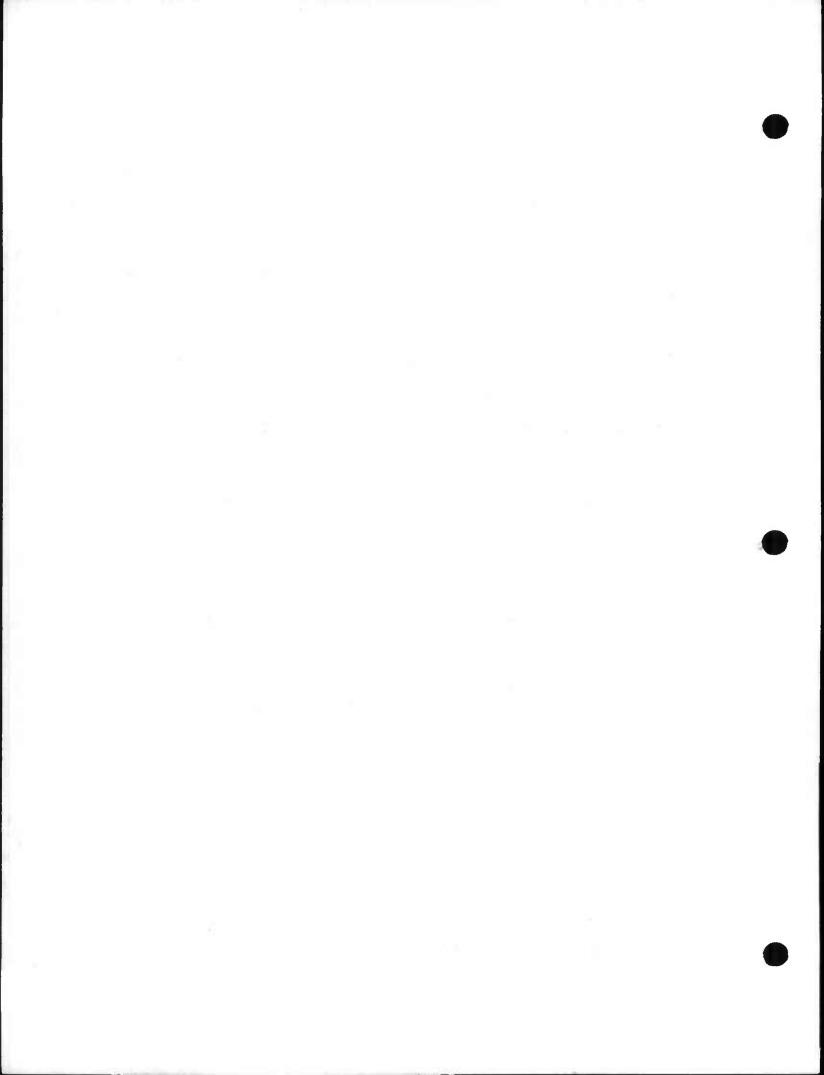


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	be executed within 24 hours
	8
	requires that the death certificate
	death
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	that
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1	A.P.
	The
)	ATTENDING PHYSICIAN:
	ATTENDING

		1 - FOR STATE REGISTRAR	STATE OF	MARYL	AND / DEPAR					NTAL HYGIE			
	1 1	1. DECEDENT'S NAME (First, Middle, Lest) Elizabeth	August	ta	Townse	n d						YEAR	TIME OF DEATH
		4. SOCIAL SECURITY NUMBER	5. SEX	In yrs. last birthday)	IF UNDER		IF UNDER 2	24 HBS 7	DATE OF BIRTH		93 BIRTHPL	12:20 P M ACE (State or Foreign	
		215-20-4771	1 □ M X 💢 F	91	YRS.	MONTHS	DAYS	HOURS	MIN.	(Morth, Day, Year) 0-4-19	01	Mary	land
Poge		Sa. FACILITY NAME (If not institution, give st				9b. CITY,	TOWN 0	R LOCATIO	N OF DEAT	н	9c. COUNT	Y OF DEAT	н
Service .	OT:	SALISBURY NURSING	& REHAB	CENT	ER	SALI	SBU	RY, M	D.		MIC	OMICC	)
ages 1	DIRECTOR	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN O	R LOCAT	ION				10	d. INSIDE CITY
e.		Maryland Wico	mico		S	alis			_				YES 2 NO
physician. burlal-transit permit. Pages 1	RAL	Rt 50 & Civic	AMORIL				101.	218			1	IN OF WHA	T COUNTRY?
ician. Il-trans	FUNER	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN	U.S. ARMED	13. W	AS DEC			ORIGIN? (Specify Y			American Indian,
phys buria	BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1	TES	2 / NO	H	yes, spe	Cuben,	, Mexican, I	Puerto Rican, etc.)		Black, W	White
attending se as the	ED B	15. DECEDENT'S EDUC	ATION		44- 000000								
	ETE	(Specify only highest grade  Elementary/Secondary (0-12)	completed) College (1-4 or 5		16a. DECEDENT'S (Give kind of life. Do NOT u	WORK done done do retired.)	uring mos	N st of working		16b. KIND OF B	JSINESS/INDU	STRY	
	COMPLET	6	Conlege (1-4 of 5	"	Home	make	r						
the hospit detached once.	00	17. FATHER'S NAME (First, Middle, Last)							_	(First, Middle, Maide			
should be	BE	Owen Seward  190. INFORMANT'S NAME (Type/Print)			- Landard Control				Bess				
5 5	2	Hazel McIntvre								ne Number, City or To isbury			0.1
may be		20s. METHOD OF DISPOSITION		20b.	PLACE AND DATE	OF DISPOSI	TION (Na	me of		DATE 20c. L			
rector, p		1 X Buriel 2 Cremation 3 Remo	rval from State	ceme	Christ	cherolace)	rch	yard	3/4	24 C	ambri		
death. Page thneral directly.		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE					D ADDRESS		al Hom	_		
		* Her by										e. M	d. 21613
E 3 & a		23. PART i. Enter the diseases, or c shock, or heart failure. I	omplications the	t caused	the death. Do								Approximate interval Between
file on,		IMMEDIATE CAUSE (Final disease or condition	0			/		_		,			Onset and Death
		resulting in death)	DUE TO		CONSEQUENCE			Pne	eumon	1a			1
B 2 2 2	z			(0	002.002.102.0	,,.							
ertificate be executing physician and cigiene prior to burian other traumatic	VTI0	Sequentially list conditions, if any, leading to immediate	OUE TO	(OR AS A	CONSEQUENCE O	F):							
ficate be physician ne prior t	FIC	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO	(OR AS A	CONSEQUENCE O	F):							
eath certi attending ntal Hygie y, or oth	CERTIFICATION	resulting in death) LAST											İ
Ne de	Ö	PART II. Other significant conditions	contributing to	death hi	ut not resulting	in the unc	lectulos	Course of	tenn in Da	rt i. 24a, WAS A	M ALFRODON		
th the land of land	CAL	ASCUD, AF	16, C	NF	, not readiting	in the dire	zerrynng	Cause A	ven m ra	PERFO	RMED?	AM	RE AUTOPSY FINDINGS AILABLE PRIOR TO IMPLETION OF CAUSE
w requires that been signed pt. of Health 3 shows any	MEDI	CANON Restun								_ 1 □ YES	2 100		DEATH?
e law requires has been sign Dept. of Heafi 23 shows	Z.	ARTHRIF.	2							-			3 .20 2 2 (6)
N: The lan ficate has State Dep	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER		ACE OF DE	ATH (Check	only one)			
SICIAN: The certificate the State	IXSI	1 YES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 28e. DATE OF	-		4 Nursi	ing Home			Other (Specify)			
NG PHYS fter this ceath with marked		1 Netural 5 Pending	(Month, D		20b. TIM	URY M	28c. INJL WOI	RIC?		Id. DEŞCRIBE HOW	INJURY OCCU	RED	
NDING R: After r death	D BY	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE O	F INJURY	— At home, ferm,	Hreet, facto			_	I. LOCATION (Street	and Number or	Rural Rout	a Number,
OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate hi hours after death with the State Ditem 28 is marked, or Item	ETE	4 Homicide determined								City or Town, State	·/		
3 7 Z	COMPLET	29e. CERTIFIER (Check only one) CERTIFYING PHYSIC											
TO THE HOSPITAL  TO THE FUNERAL  De filed within 72  IMPORTANT: If	CO	2 MEDICAL EXAMINER	t: On the basis of s	xamination	and/or investigation	on, In my op	ilnion, de	eth occure	d at the tim	e, date and place, a	and due to the	cause(s) ar	d manner as stated.
Por Fied	BE	29b. SIGNATURE AND TITLE OF CERTIFIER	m	w	11				ISE NUMBE	R	29d. DATE S	SIGNED (M	onth, Day, Year)
₽₽8₹	2	30. NAME AND ADDRESS OF PERSON WHO			-	Print)		D 3	39813			100	17-3
5		MTOUS DE LOUIS					Æ,	SALTS	BURY	, MD. 21	801		
		31. DATE FILED (Month, Day, Year)	32. REGISTRA	R'S SIGNA	TURE		_,		~~1\4		-01		
	ì	MAR 23'93	7 marriago	Mal - N	and the same								



	REGISTRAR CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last)  LAURETTA B. TRUMPOWER  2. DATE OF DEATH 3/15/93 3. TIME OF DEATH MONTH									
	Lauretta Trumpower B. TRUMPOWER March 5/1993 1431 PM									
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vis. lest birthday) IF INNER 1 YEAR IF INNER 24 HIRE 7 DATE OF BIRTH 6. SPETIAL ACE (SAME OF FOLIA)									
	214-09-9429 1 M 2 XF 83 YRS. MONTHS DAYS HOURS MIN. (Month, Day, Year) 6/26/09 Edgemont, MD									
	9a. FACILITY NAME (If not institution, give street and number)  9b. CITY, TOWN OR LOCATION OF DEATH  9c. COUNTY OF DEATH									
<u>۳</u>	Washington County Hospital Hagerstown Washington									
15	RESIDENCE OF DECEDENT									
DIRECTOR	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIGE CITY LIMITS?									
	MD Washington Hagerstown 1 № Yes 2 🗆 NO									
¥	10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY?									
FUNERAL	12 South Walnut ST Apt 607 21740 USA									
5	11. MARITAL STATUS  12. WAS DECEDENT EVER IN U.S. ARMED 1 Never Married  13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No— Black, White, atc.  14. RACE — American Indian, Black, White, atc.									
ВУ	3 Widowed 4 Divorced IF YES, GIVE WAR OR OATES TO Specify: Whit									
	15. DECEDENT'S EDUCATION 188. DECEDENT'S VISUAL OCCUPATION 188. MIND OF BUSINESS (MIND									
COMPLETED	(Specify only highest grade completed)  (Give kind of work done during most of working									
1	College (1-4 or 5+)									
₩ O	2 Nurse Doctor's Office  17. FATHER'S NAME (First, Middle, Last)  18. MOTHER'S NAME (First, Middle, Meiden Surname)									
Ö	John C. Trumpower Sr Alice M. Bachtell									
BE										
2	Mrs. Robert Bowen  196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town. State, Zip Code)  21742  13310 Fairgreen Circle, Hagerstown, MD									
	20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of									
100	No.   Stouffer Cemetery   Stouffer Cemetery   Stouffer Cemetery   3/19 Washington CO, MD									
1	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY Grove Funeral Home, Inc.									
- 3	50 S Broad St Waymeshore DA 17268									
	23 PART I Enter the diseases or complications that outside the death Donat the									
	interval Between									
	IMMEDIATE CAUSE (Finel disease or condition									
	disease or condition resulting in death)  e. KESPIRATORY FAILURE  DUE TO (OR AS A CONSCIDENCE OF):									
_										
0	Sequentially list conditione,  If any, leading to immediate  Due to (or as a consequence of):									
ΑT	cause. Enter UNDERLYING									
띮	CAUSE (Disease or injury that initiated events OUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	resulting in death) LAST									
Ö	PART II OU III III III III									
DICAL	PART II. Other algorificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY FINOINGS AMAILABLE PRIOR TO									
ă	ACUTE NOTICULITIS MULTIFOCAL 1 YES 2 NO COMPLETION OF CAUSE DOT DEATH?									
ME	PRE-RENTE AZOTEMIA ATRIAL TACHY- 1 VES 2 INO									
Z	- MALNUTRITION CARSIA									
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:									
ΥS	1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify)									
	27. MANNER OF DEATH  28a. DATE OF INJURY (Month, Day, Year)  28b. TIME OF INJURY AT WORK?  28d. DESCRIBE HOW INJURY OCCURED									
B	2 Accident Investigation Investigation Investigation									
8	3 Suicide 8 Could not be detarmined 28e. PLACE OF INJURY — At home, tarm, street, factory, offica building, etc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number. City or Town, State)									
E										
COMPLETED	29e. CERTIFIER (Check only one)  CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(a) and manner as stated.									
ő	one) 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) end manner as stated.									
BE (	29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)									
TO B	January 800 600 16 93									
F	36. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)									
	PAMERA FOX BRANFOLD MD 1799 HOWER RD. HAGERSTOWN MD 21740									
	31. DATE FILED (Month, Day, Year) 32-REGISTRAR'S SIGNATURE									
- 1	MAR 19 1993 Fall Sinder Reduct									



BALTIMORE, MARYLAND 21215-002

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospi	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	SUNO	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 21<sup>DAY</sup> 1993<sup>YEAR</sup> THEODORE JOSEPH TAYLOR MARCH 7:35p 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 07-22-1917 236-18-7103 75 West Virginia 1 📉 M 2 🗌 F 99. FACILITY NAME (If not institution, give street end number)
PHYSICIANS MEMORIAL HOSPITAL 9c. COUNTY OF DEATH CHARLES 96. CITY, TOWN OR LOCATION OF DEATH LA PLATA FUNERAL DIRECTOR RESIDENCE OF DECEDENT 10b. COUNTY 10e. STATE 10c. CITY, TOWN OR LOCATION Maryland Charles Indian Head 1 TYES 2 THO 10e. STREET AND NUMBER 101. ZIP CODE 20640 10g. CITIZEN OF WHAT COUNTRY? #7 Kenwood Place 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 15 YES 2

IF YES, GIVE WAR OR DATES

2-45 - 12-45 1 Never Married Married BY White 3 Widowed 4 Divorced COMPLETED 16s. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) US Government Rigger 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle, Meiden Surrame) Sara Catherine Ramsey George H. Taylor BE 19a. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Yown, State, Zip Code)
7 Kenwood Place, Indian Head, Md. 20640 9 Gloria J. Taylor 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE 3-24 Waldorf, Md. Trinity Memorial Gardens 21. SIGNATURE OF FUNERAL SERVICE-LICENSEE MARK Brohawn M00053 22. NAME AND ADDRESS OF FACILITY Trinity Memorial Gardens P. O. Box 156, Waldorf, Md. 20604-0156 23. PART . Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate ehock, or heert feliure. List only one ceuse on eech line. interval Between **IMMEDIATE CAUSE (Finel Onaet and Death** disease or condition CARCINOMA BLADDER may resulting in death) DUE TO (OR AS A CONSEQUENCE OF): BONES METASTATI C PHYSICIAN: MEDICAL CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury that Initiated eventa DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 TYES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 Pinpetient 2 ER/Outpetient 3 DOA OTHER: 1 TES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 Natural
2 Accident 5 Pending Investigation BY 1 YES 2 NO 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide ETED. 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide COMPL ERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) end manner ee stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner se stated. 29b. SIGNATURE AND TITLE OF CERTIFIER

Mattin

32. REGISTRAR'S SIGNATURE

Julie Davidson Boylette

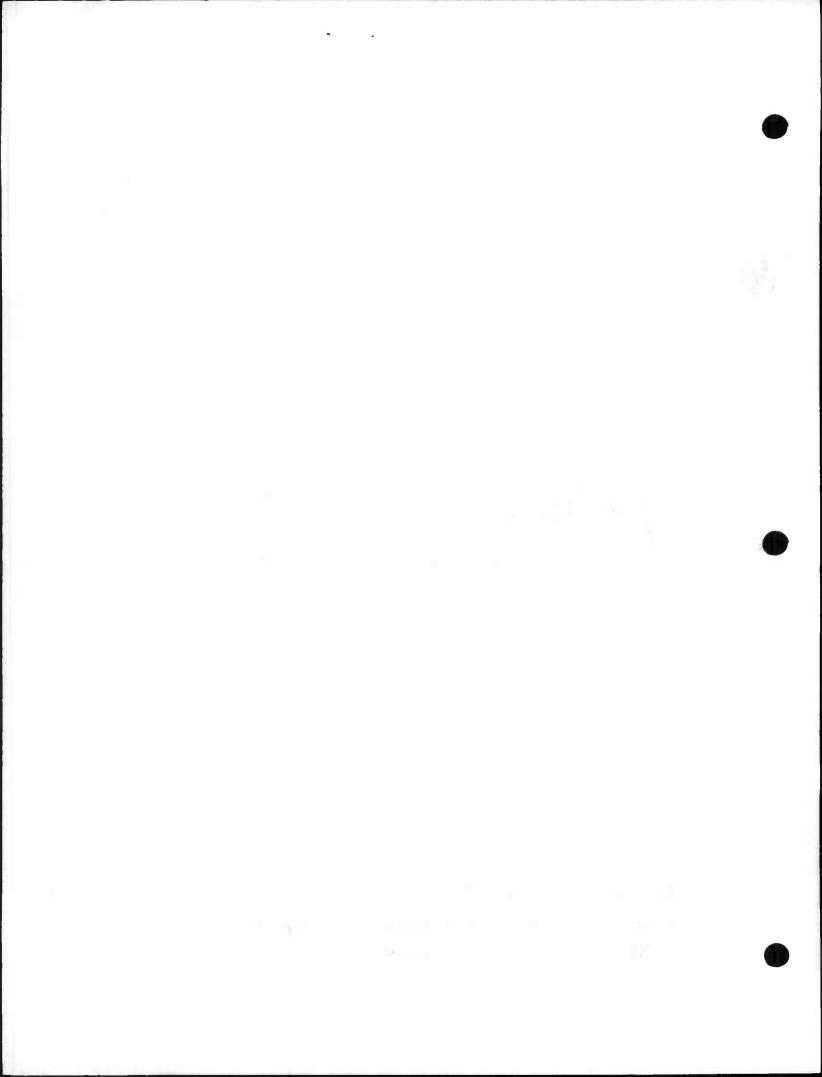
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

KRISHAN MATHUR M.D.

31. DATE FILED (Month, Day, MAR 2 3

29d. DATE SIGNED (Month, Day, Year)

PEMBROOKE SQUARE #213 HIGHWAY 301S WALDORF MARYLAND 20603



TO THE HOSPITAL OF ALTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Plage 8 may be retained by the hospi	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the lumera director, pages 5 abouts be described within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	THE CENTREMENT OF THE CONTRACT
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law n	TO THE FUNERAL DIRECTOR: After this certificate has bee be filed within 72 hours after death with the State Dept.	IMPORTANT: It item 28 is marked, or item 23 s	TO-DE COMBIETED BY BUYSICIAN: MEDICAL DEBTICIONI

	REGISTRAR			OLITI	HIOAI	LOI	DEATH		REG. NO.				
1. DE	ECEDENT'S NAME (First, Middle, JUDY	MARIE	7717	MPSON			-	2. DATE (	OF DEATH DA	Y 00	YEAR	3. TIME OF DEATH	
4 9/	OCIAL SECURITY NUMBER	5. SEX		In yrs. lest birthd		ER 1 YEAR	IF UNDER 24 HRS.	_		93		6:26P	
		1 M 2		•	MONTHE		HOURS MIN.	7. DATE (	Day, Year)		Country	•	
	77-38-6674 FACILITY NAME (If not institution,					TOWN.	OR LOCATION OF D		10/42	9c. COUNT	Ohi		
	ACRED HEART H		or)		96. CI					7.5			
	SIDENCE OF DECEDEN						UMBERLAN	עו		A	LLEC	ANY	
	STATE 10b. CO	DUNTY		10c.	CITY, TOWN							10d. INSIDE CITY	
U	HIO	Belmont	5		FLUS	SHING	į					LIMITS?	
	STREET AND NUMBER BOX 434 Nort	hwest S	St.	101. ZIP CODE 43977						10g. CITIZEN OF WHAT COUNTRY? USA			
11. M	MARITAL STATUS			FR IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC					? (Specify Yes	or No— 1	14. RACE	ACE — American Indian.	
III -	Never Married 2 Married	If yes, specify Cuben, Mexican, Puerto Rican, et 1 YES 2 XNO Specify:							Specif	, White, etc.			
3 🗆	Wildowed 4 Divorced								ороси	white			
	15. DECEDENT'S (Specify only highest			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working					KIND OF BUS	INESS/INDU	STRY		
E	Elementary/Secondary (0-12)	College (1-4	(Give kind of work done during most of working life. Do NOT use retired.)  Self employeed wood  18. MOTHER'S NAME (I										
	12						d crafter cra						
17. F#	ATHER'S NAME (First, Middle, Las	et)					AME (First, M	liddle, Maiden					
	Paul Edward	Delane	Ruby Frances						Moo	re			
19a. I	INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, S										
	Richard D.	Thomps	Box 434 Northwest St., Flush							Oh	io 43977		
	METHOD OF DISPOSITION Burlel 2 Cremation 3	version and the	206. PLACE AND DATE OF DISPOSITION (Name of Competer), grematory of other place) ROCK Hill Cem. 3/15/93 Flux						ATION — CI	ity or Toy	en. Stata		
	Donation 5 Other (Specify)		R Cem	etery, crematory OCK H	or other place	Cem.	. 3/	15/9	3 Flu	shin	a, C	hio	
21. 37	SCHATURE OF FUNERAL SERVI	CE LICENSEE	0 1		22	. NAME A	ND ADDRESS OF F	ACILITY					
4	11 Just at	HA	alu	Hafer Chapel of th						_			
100	Con Jaco		1		1302 National Highway, I he death. Do not enter the mode of dying, such as cardiac or respiratory arre							1e,MD215	
Sequif an cause CAU that	quentially list conditions, ny, leading to immediate se. Enter UNDERLYING JSE (Disease or injury t initiated events utiling in death) LAST	TRICULA UE TO (OR AS A TERIOSO UE TO (OR AS A	CONSEQUENCE CONSEQUENCE	E OF): C HEA E OF):		ISEASE					Onset and Deat		
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PAR	T II. Other significant cond	ditions contributi	ng to death be	ut not resulti	ng in the u	inderlyin	g cause given in	Part I.	24a. WAS AN PERFOR	MED?		WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO	
	WAS CASE REFERRED TO MEDIC	AL				26. P	LACE OF DEATH (C	heck only one	)				
15	EXAMINER?	HOSPITA 1 Inpatien		atlent 3 🗆 DO	OTHE	ER:	ne 5 🗆 Residence						
27. M	IANNER OF DEATH	26s. DA	TE OF INJURY		TIME OF	_	JURY AT	_	CRIBE HOW IN	JURY OCCU	RED		
1 0	Natural 5 Pending		onth, Day, Year)	100	INJURY M	W	ORK? YES 2 NO			3000 10 - 10			
	Accident Investigs  Suicide 6 Could no	26a. PL	ACE OF INJURY	— At home, far	m, street, fa			28f. LOCA	TION (Street a	nd Number o	r Rural B	oute Number	
3		N DU	ilding, etc. (Spec	ify)					Town, State)			,	
	Homicide determin	eq pe						cause(a) and manner as stated.  eta and place, and due to the cause(a) and menner as stated.					
290. 0	Homicide determin	PHYSICIAN: To the b	eat of my knowl	edge, death oc	curred at the pation, in my	time, date opinion, o	and place, and du feath occured at the	time, data	e(a) and man	ner as stated I due to the	d. cause(a)	and menner as stated.	
290. 0	Homicide determin	PHYSICIAN: To the E	eat of my knowl	edge, death oc	curred at the pation, in my	time, date	earth occured at the 29c. LICENSE NU	time, data	and place, and	dua to the	cause(a)	end menner se stated. (Month, Day, Year)	
290. 0	Homicide determin	PHYSICIAN: To the E	s of axamination	edge, death occ and/or investig	pation, in my	time, data	feath occured at the	time, data	e(a) and man	dua to the	cause(a)	(Month, Day, Year)	
290. (	Homicide determin	PHYSICIAN: To the bankiner: On the bankiner	DPTY	MED E	ation, in my	time, date	feath occured at the 29c. LICENSE NU	time, data	e(a) and man	dua to the	cause(s)	(Month, Day, Year)	
290. G	Homicide detarmin	PHYSICIAN: To the basines: On the basines	DPTY	MED E	gation, in my X Type, Print)	opinion, o	29c. LICENSE NU D 0915	time, data	e(a) and man	dua to the	cause(s)	(Month, Day, Year)	

			1. DECEDENT'S NAME (First, Middle, Las	T lease of the								AY	YEAR	3. TIME OF DEATH
		No.	GEORGE THOMAS T	5, SEX	6. AGE (In yrs. le:						MARCH 13,	199		12:23 P M
			236 14 0673	1 X M 2 - F	80	YRS.	IF UNDER	DAYS	IF UNDER	MIN.	7. DATE OF BIRTH (Month, Day, Year) NOV 8 19	1 2	6. BIRTH Country	PLACE (State or Foreign  M.d.
	A TON		9a. FACILITY NAME (If not institution, giv		1 00	1110.	9h CITY	TOWN (	OR LOCATI	ON OF D			INTY OF DI	
- 1	4	TE I	SACRED HEART HO	,			96. CITY, TOWN OR LOCATION OF DEATH  CUMBERLAND						ALLE	
- 1	2	E	RESIDENCE OF DECEDENT				<u> </u>	-						AR(1
	1	DIRE	10e. STATE 10b. COUR	TY		10c. CIT	Y, TOWN C	R LOCA	TION					10d. INSIDE CITY LIMITS?
	a a			Allegany	7		Lo	nac	onin	ıg				1 - YES 2 X NO
	ending physician. as the burial-transit permit	FUNERAL	10e. STREET AND NUMBER					101	f. ZIP COD			10g. CIT		HAT COUNTRY?
	an. transi	E I	19 Beechwo						215				U	
20	thysic:		11. MARITAL STATUS  1 Never Married 2 Married	FORCES?	NT EVER IN U.S. AF	NO If yes, specify Cuben, Mexi					in, Puerto Rican, etc.)	s or No-	14. RACE — American Indian, Black, White, etc.	
215-0020	the b	A	3 Widowed 4 Divorced		WAR OR DATES VW 2	DATES 1 TYES 2 NO Specific					y:	Spech	White	
215	attend se as	입	15. DECEDENT'S El (Specify only highest gra	UCATION	16a, DE		USUAL O				16b. KIND OF BU	SINESS/INI	DUSTRY	
213	o la lor ne	4	Elementary/Secondary (0-12)	College (1-4 or 5		Do NOT u	work done ( se retired.)	during mo	st of working	ng				
9	ched ched	COMPLETED	Unknown		We	stva	ico	Emp	love	ee	Paper	Mar	nuf.	
A	the ho detact											ame)		
RY	ad be	B	Alex Timney	<del></del>							a Warnic			
MARYLAND	y be retained by the hospital or attending physician, lage 5 should be detached for use as the burial-tran be notified at once.	2	19a. INFORMANT'S NAME (Type/Print)	1 - 4	19						Route Number, City or Tox			W1 010//
Щ,			Elizabeth W	ebster	20b.PLACE									Md.21046
OR	e 6 may be rector, page must be r		Burial 2 Cremation 3 Re	movel from State	cometery, cre	metory or o	ther plece)	TON (No	ame of	1 D	ark 3-18	_ O 3	City or To	wn, State
Σ	Page il dire		21. SIGNATURE OF PUNERAL SERVICE		-	bulls	22.	NAME A	ND ADDRE	SS OF FA	CILITY	7.3	Cui	Md.
BALTIMOR	affer death. Page 6 may be by the funeral director, page imoval.		· Tredw	War	nu	1		111	Chur	ch c	Funeral S	nort	Md	na.
	5 5 5		23. PART-1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest,  Approximate											
			IMMEDIATE CAUSE (Finei	M					6					Interval Between Onset and Death
_			disease or condition resulting in death)	. Ask	1/a / (on		1041	ron	4					1475
68760,	Z 5 - 6			a. Asp.  Due to	OR AS A CONSE	OUENCE O	3:							11
68	e be execute sician and c nior to buria traumatic	ERTIFICATION	Sequentially list conditions,	b. DUE TO	O (OR AS A CONSE	DUENCE O	7/) C 4	75						7095
ô	sician rior t	Ĭ.	if any, leading to immediate cause. Enter UNDERLYING		(		,,							į
. B		Ē	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CONSEQUENCE OF):										
P.0	E 5 - 6		resulting in death) LAST	d										
5,	E 8 5	O	PART II. Other aignificant conditi	ona contributing to	death but not	regulting	in the un	derivin	o cause o	aiven in	Part I. 24s. WAS AN	AUTOPSV	245	WERE AUTOPSY FINDINGS
ECORDS	36 =	EDICAL	Ischemic co	rdeo myo	outles.	con	sest	ive	hea	1	PERFO	RMED?	240.	AMAILABLE PRIOR TO COMPLETION OF CAUSE
S	signed Health a		fullur								1 TES	∑>NO		OF DEATH?
<u>~</u>	law requires as been sign bept, of Healt 23 shows	2 3									_			1 YES 2 NO
VITAL	AN: The law requirements that been State Dept. of Item 23 sho	SICIAN:	25. WAS CASE REFERRED TO MEDICAL					28. PI	ACE OF D	EATH (Ch	eck only one)			
7	certificate the State of the State	YSIC	1 YES 2 NO	HOSPITAL:	☐ ER/Outpatient 3	□ DOA	OTHER		ne 5 🗆 Re	sidenca	8 Other (Specify)			P
N OF	The this	ВУ РН	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation		F INJURY Day, Year)	28b. TIW	E OF IURY M		PURY AT DAK?	NO	28d. DEŞCRIBE HOW	NJURY OC	CURED	
DIVISION	O V O M	LED B	3 Suicide 6 Could not b	28a. PLACE (	OF INJURY — Al ho	me, larm,	streel, fact	ory, offic	•		261. LOCATION (Street City or Town, State)		r or Rural R	oute Number,
2	DIRIC DIRIC	١٣	294, CERTIFIER CERTIFYING PHY	SICIAN: To the heat or	f my knowledge de	oth occur	ad at the H	4-1-	and alass		to the cause(a) and ma	- XV		
	Z Z Z Z	COMPL									Ilme, data and place, as			and manner as stated.
	<b>2 3 4 4</b>	296. SIGNATURE AND TITLE OF CERTIFIER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. DATE SIGNED										E SIGNED	(Month, Day, Year)	
	283	2	30. NAME AND ADDRESS OF PERSON I	HO COMPLETED CALL	ISE OF DEATH (ITE	M 27) (Type	. Print)		U	16	700		5-	() 13
	2		Thomas	· Doci	in My	1	74	in	2an	5%.	, Lonace	on in	s, he	21539
			MAR 18	1993 <sup>32. REGIST</sup>	EGISTA R'S SIGNATURE									

White

US

Md Aliegany

19 Beechwood St.

WW 2

Paper Manuf. Westvaco Employee

21539

X

Lonaconing

Clara Warnick

8410 Kings Meade Way, Columbia, Md. 21046

Sunset Memorial Park 3-18-93 Cumberland

Boal-Warnick Funeral Service 111 Church st. Westernport, Md.

Unknown

Alex Timney

Elizabeth Webster

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The !aw requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	REGISTRAR				AIE OF	DEAL			EG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF	DEATN			3. TIME OF DEATH	
	PAUL MIII	ED	III	MBERG	2EB			MADCE	1 7		YEAR	:25 P M	
1 1			AGE (In yrs. last bi		F UNDER 1 YEAR	IF UNDER		MARCH					
		1 X M 2 D F		1	ONTHS DAYS	HOURS	MIN.	(Month, De		,	Country)	LACE (State or Foreign	
	234-10-9730		79	YRS.		- 1000	500	05-3	1-13	3	VIR	GINIA	
1 3	9a. FACILITY NAME (If not institution, give street	et and number)		91	b. CITY, TOWN C	OR LOCATIO	ON OF DE	ATH		9c. COUN	TY OF DEA	TH	
E E	Memorial Hospital	S. Modian	1 Conto	_	Cumber	1001					A 1 1 a		
IK	RESIDENCE OF DECEDENT	W Medica	I Cente	Τ [	Cumber	Tand					Alle	gany	
DIRECTOR	10a. STATE 10b. COUNTY		10c. CITY, TOWN OR LOCATION							10d, INSIDE CITY			
E E	MARYLAND ALLE	GANY		ROW	LING	CDEE	M			LIMITS?			
	10e. STREET AND NUMBER	. Unit		DOW						1 TES 2 X NO			
<b>₹</b>	106. STREET AND NUMBER				101	. ZIP CODE			- 1	10g. CITIZ	EN OF WH	AT COUNTRY?	
Ü	12526 NORTH CRES	SAP STRE	ET			215	0.2			11.	S.A.		
FUNERAL	11. MARITAL STATUS	2. WAS DECEDENT EV	VER IN U.S. ARME	D	13. WAS DEC	ENDENT OF	F HISPAN	IC ORIGIN? (S	pecify Yes			- American Indian.	
	1 Never Married 2 X Married	FORCES? 1	YES 2XXNO		If yes, sp	ecity Cuber	n, Mexicar	n, Puerto Ricer	ı, etc.)	1000		- American Indian, White, atc.	
BY	3 Widowed 4 Divorced	ii 125, Give Will	ON DATES		1 1 163	2 X NO	Specify.				Specify:	WHITE	
ETED	15. DECEDENT'S EDUCA	TION	16a DECER	DENT'S HE	UAL OCCUPATION	ON		105 800	D OF BUILD	INESS/INDI			
E	(Specify only highest grade co	mpleted)	(Give i	kind of work	k done during mo	ist of working	g	100, KIN	U OF BUSI	INESS/IND	JSTHY		
2		College (1-4 or 5 +)		LICE				D	AILR	OAD			
ž	12		10		ли				AIL	TUAD			
COMPL	17. FATHER'S NAME (First, Middle, Last)					18. MOTN	IER'S NAM	WE (First, Middl	e, Malden S	iumame)			
BE	WALTER UMBERGER					l et	TA	JANE	LINE	EMO	0.0		
	19a. INFORMANT'S NAME (Type/Print)		19b, M	AILING AD	ODRESS (Street e								
일	VERNA GEORDON UM	REDGED									,	D 21502	
	20a. METNOD OF DISPOSITION	IDLKULK					31.						
	1 Burial 2 Cremation 3 Remove	al from State	20b. PLACE AND cemetery, cremat	ory or other	nlace!	me of		DATE	20c. LOC	ATION — C	alty or Town	n, Stata	
	4 Donation 5 Other (Specify)		MD. A	NATO	MY BO	ARD	3 - 1	8-93	BA	LTI	MORE	, MD	
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE			22. NAME AN								
	1/2 1. 19)	41	-1		MAR	YLAN	D A	NATOM	Y BC	ARD			
	Jonay 11.	Upchel	uch)		655	W.B	ALI	.St	BALT	IMO	RE,M	D 21201	
- 1	23. PART I. Enter the diseases, or cor shock, or heart failure. Lis	mplications that ca	sused the death	. Do not	enter tha mo	da of dyle	ng, auch	as cardiac	or respin	atory arre	est,	Approximate	
	IMMEDIATE CAUSE (Fine)	Only one cause	A /		1							Interval Between Onset and Death	
1		1//	. 0. 11 1	mai.	1 ~	0 .						Oliset and Death	
	disease or condition resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):												
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NO	resulting in death) a	Ch.	080	rdo	tes	( )							
ATION	Sequentially list conditions, if any, leading to immediata	Ch.	AS A CONSEQUE	rdo	tus								
ICATION	resulting in death) a	DIVE TO (OR	AS A CONSEQUE	NCE OF)	les			Λ					
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	BALTIMORE, MARYLAND 21215-0020
THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	hours after death. Page 6 may be retained by the hospital or attending physician.
THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit	lled in by the funeral director, page 5 should be detached for use as the burial-transit permit
In fied within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	1, or removal.
'IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	s medical examiner must be notified at once.

LAXM'N BERWA
31. DATE FILED (Morrit, Day, Year)
MAR 1 8 1993

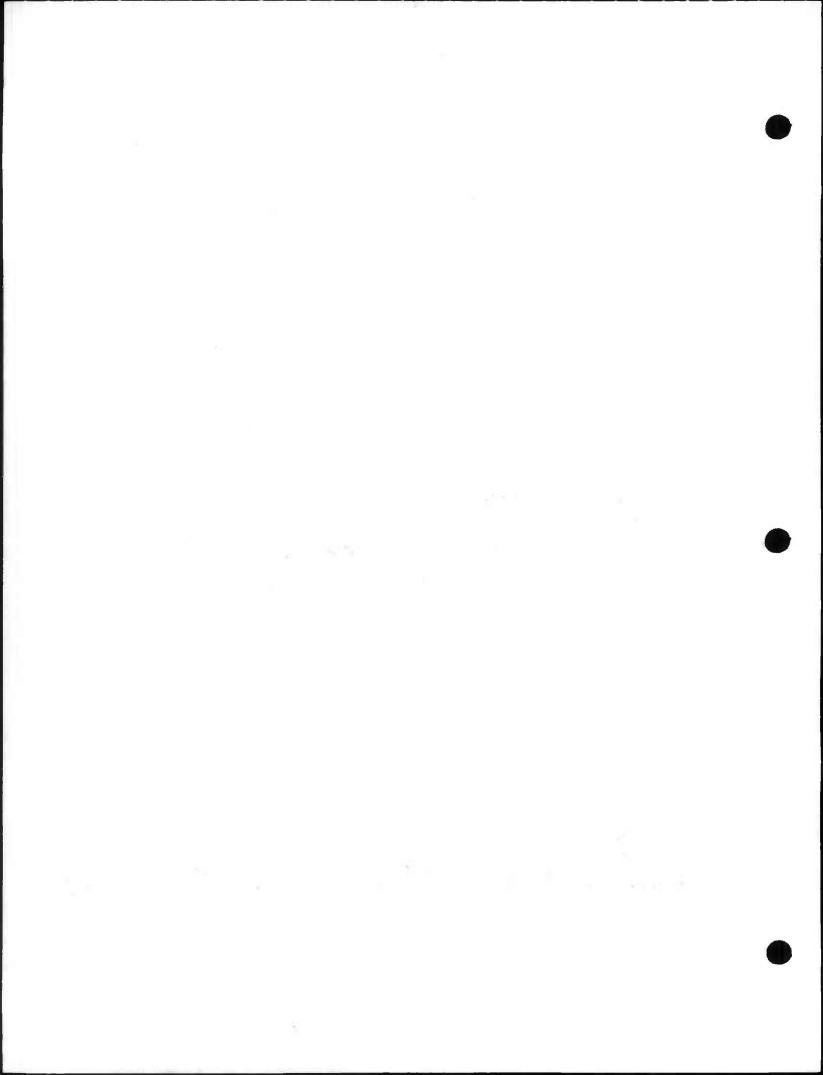
	1 - FOR STATE REGISTRAR		STATE OF I	MARYL			TMENT ICATE				MEN		GIEN S. NO			0,50	
	1. DECEDENT'S NAME (First	, Middle, Last)									2. [	DATE OF DE	_			3. TIME OF OE	TH A
	TOEL	TCA	MA	RiE	( )	0.16	0 -		7			HONTH		AY	YEAR	3. TIME OF 0E	" 4
	4. SOCIAL SECURITY NUMI		5. SEX	-	V		RIE				-	5		2	13	10.30	) M
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	9a. FACILITY NAME (If not II	stitution, give :	street and number)		9b. CITY,	TOWN (	OR LOCATI	ON OF DE	ATH	-			NTY OF	DEATN			
는 는	Souther	MA	Pul An	NHO	SO.	+01	(11	: 1	1+	4.1	N	20		0		EGEOR	pr.
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Ä	10a. STATE	10b. COUNT	Y			10c. CIT	Y, TOWN OF	LOCAT	TION							10d. INSIDE CIT	Y
DIRECTOR	Maryland	Princ	e George	15		Sea	brook	-								LIMITS?	
1	10e. STREET AND NUMBER					Dec	DI CO	_	. ZIP COD		_			140- 017	TEN OF	WHAT COUNTRY?	, NO
FUNERAL	9417 Frank	lin Ar	7ODUO											-		WHAT COUNTRY?	
쀨		TIII A							207						A.		
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BY	3 X Widowed 4 Divo		IF YES, GIVE V						2 X NO			orto riicani, a			Spec		.0
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교		Ac	ccoun	tant					Home	Mi	issic	nary	7				
COMPLETED	17. FATHER'S NAME (First, M					18. MOT	NER'S NA	ME (F	irst, Middle, A								
EC	Charles M.								rring								
00	19a. INFORMANT'S NAME (	100	- MAIL INC	ADDRESS	(Da				Number, City					_			
ဥ	Roy Von Br																
							, Sea	br	brook, Maryland 20706								
	20a. METNOD OF DISPOSIT 1 X Burlaj - Cramatic	on 3 🗆 Rem	oval from State			ry, cremetory or other place)						DATE 2	Oc. LO	CATION —	City or To	own, State	
	4 Donation 5 D Other			_   R	oseo	emetary or other place)  Mart						insb	urg,	West Vi	rgin		
	21. SIGNATURE OF FUNERA	L SERVICE LA	CEHRICE.				22. NAME AND ADDRESS OF FACILITY										
	1 1G	RA	Moore			Rendon/Hale Lanham Funer 9013 Annapolis Rd., Lnaha						al H	ome				
	22 DADT I Diver the	1 V	V CCC 4	-	4.45		901	3 A	nnap	OIIS	R	a.,Ln	ana	m, Ma	ryla	and 2070	6
	shock, or h	aart fallure.	List only one far	t cause	a the de	ath. Do r	Dt antar t	ha mo	da of dy	ing, suci	h aa	as cerdiac or reapiratory arrest, Approximate Interval Retween					
1 1	IMMEDIATE CAUSE (Fir		0			01	1	1		11		Interval Between Onset and Death					
	disease or condition resulting in death)	<b>→</b>	. 191	1/		XV	O.C.	Ł		dla	1	- TA	Onset and Daet				
	reculating air dealth,		DUE O	(OR AS	COMSE	WENCE OF	r): •		1	MO	1/	- Sname					
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	Sequentially list condit		n. DUE/NO	(OR AS	CONSEC	DUENCE OF	j:		-/	A	K	600	2.1.	,			
	If any, leading to imme- cause. Enter UNDERLY								1	0						į	
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I E I	resulting in death) LAS	т					,									į	
CERTIFICATION		•	d													+	
ایا	PART II. Other significa	nt condition	a contributing to	death b	ut not r	esulting i	n the und	eriying	g ceuse g	given in	Part	i. 24a. W	AS AN	AUTOPSY	246	. WERE AUTOPSY F	INDINGS
20													RFOR			AMAILABLE PRIOR	
1 W I												1 0 1	E\$ 2	Х) ио		OF DEATH?	
≥																1   YES 2	NO
ÿ																	
5	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:						ACE OF D	EATH (Che	ck on	fy one)					
PHYSICIAN:	1 TYES 2 NO		Minpatient 2	ER/Outp	patient 3	□ DOA	OTHER:		e 5 🗆 Re	sidenca	8 🗆 6	Other (Specif	v)				
1 = 1	27. MANNER OF DEATH		28a. DATE OF	INJURY		26b. TIM	E OF 2	8c. INJ	URY AT		_	DESCRIBE I		JURY OC	CURED		
	ΔΛ –	Pending	(Month, D	ey, Year)		INJ	URY M		RK?	NO I							
B	3 D Sulalda	Investigation	26a. PLACE O	F INJURY	— At ho	me, farm, s	treet fector			-	201	LOCATION /	tmot e	and Misseshou	or Dunnt	Route Number,	
		Could not be determined	building,	atc. (Spec	cify)			,,			201.	City or Town,	State)	no reamber	Or Huran	roote rumoer,	
릴	(Check only		CIAN: To the best of														
COMP	/ MENEDI	CAL EXAMINE	R: On the besis of e	xaminatio	n and/or I	nvestigatio	n, in my opi	nion, d	eath occur	ed at the	time,	data end pla	ce, en	d due to th	e cause(	a) and manner as	stated.
ш	286 SIGHATURE AND TITLE	OF CERTIFIE	\ AA S	1	#	71	1	. 1	290 LICE	NSE NUM	PER	~ /		29d. DAT	E CIGNED	(Month, Day, Year)	
0	1-1	my.	m/1/1	)	VH	lu	du	0	1	-21	12	235	ļ	<b>&gt;</b> /	3/1	6/93	
유	30. NAME AND ADDRESS OF	PERSON WN	O COMPLETED CAU	SE OF DE	ATN (ITEN	1 27) (Type,	Print)	1	-					-	1	7 ()	
				1 /	^		^				1						

CLINTON, Md. 201

AUE # 6-101

32. REGISTRAR'S SIGNATURE

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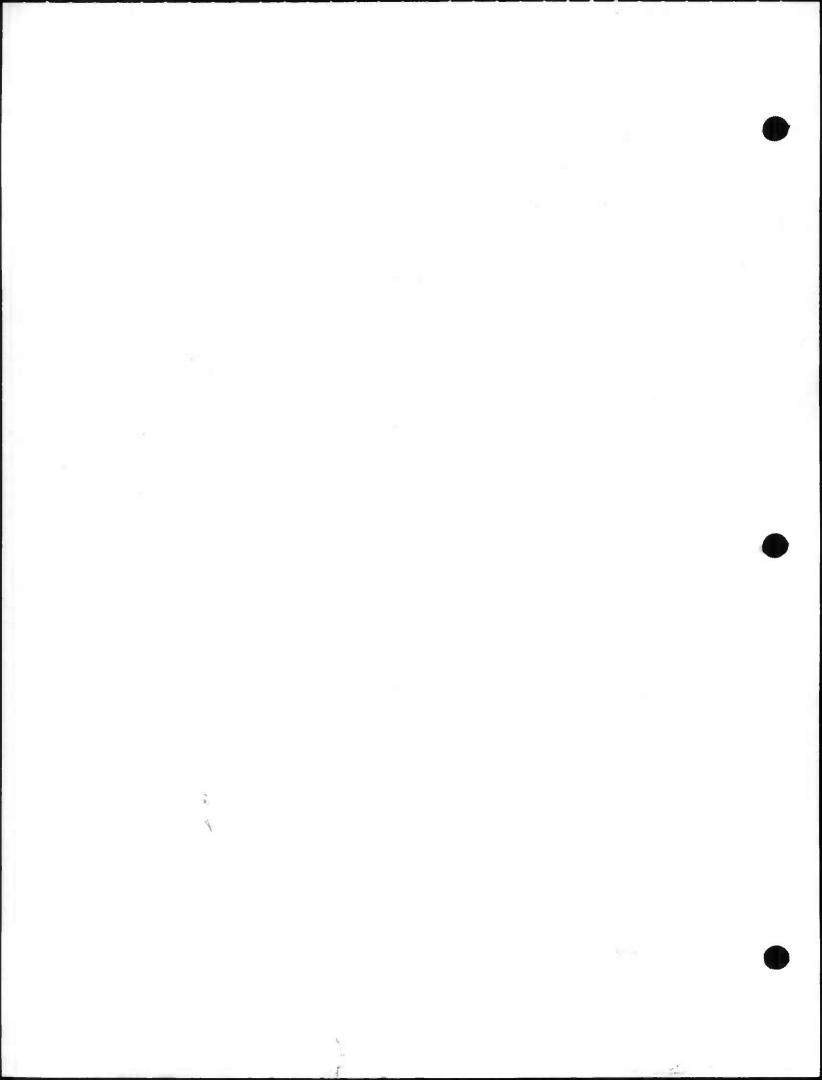


1993

3. TIME OF DEATH

WALLACE

		4. SOCIAL SECURITY NUMBER	5. SEX	A ACE /In Inc					L BB L	- 1	33 7017760			
		320 7 330 7 330 330 330 330 330 330 330 33	t D M 2 D F	6. AGE (In yrs. les		IF UNDER 1 YE		MIN.	7. DATE OF BIRTH (Month, Day, Year)	100	8. BIRTNPLACE (State or Foreign Country)			
용		212-14-9395 A  9a. FACILITY NAME (If not institution, give str	Λ	90_							2 Mitchv. Md			
pinou	<u>ac</u>						WN OR LOCATIO		EATN	75 500	NTY OF DEATN			
<b>EE</b> .	DIRECTOR	6508 Maureen Ct	. Cheve	erly		Che	verel	у,		Р.	G.			
基礎》	HE	10s. STATE tob. COUNTY			t0c. CITY,	TOWN OR LO	CATION				tod. INSIDE CITY			
-	=	Md.									t YES 2 NO			
8	¥	10e. STREET AND NUMBER					10f. ZIP CODE			10g. CITIZEN OF WHAT COUNTRY?				
ending physician. as the burial-transit	FUNERAL	6508 Maureen Ct	. Che	everly	, Md		207	85		U.	S.A.			
ysicia inaLti	5	1t. MARITAL STATUS t Never Married 2 Married	12. WAS DECEDENT FORCES? 1	EVER IN U.S. AR	MED	t3. WAS	OECENDENT O	F NISPAN	NIC ORIGIN? (Specify Yea or No— 14. RACE — American Indian, an, Puerto Rican, atc.) 14. RACE — American Indian, Bleck, White, atc.					
of of	Mg	3 🛱 Widowed 4 🗌 Divorced	IF YES, GIVE W	AR OR OATES			YES 2 X NO	Specify: Black						
attending physician. se as the burial-tran	ED	15. DECEDENT'S EOUC				I ISUAL OCCUP		16b. KIND OF BUSINESS/INDUSTRY						
for use	Ш	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5 +	- Ma	tve kind of wo Do NOT use	ork done during retired.)	most of working	ng		. Of Defense				
ospita thed 1	AP.	12			pply	Supe	ervis	Ft. Me		Jerense				
the hospital or detached for u	COMP	17. FATHER'S NAME (First, Middle, Last)  18. MOTHER'S NAME (First, Middle, Maiden Surname)												
20 P	BE (	Samuel Wallace					al June							
Death. Page 6 may be retained by funeral director, page 5 should be axaminer must be notified at	0	19a. INFORMANT'S NAME (Type/Print)							Route Number, City or Tow					
y be nage 5		Mark A. Ward		6	508	Maure	een Ct	t.						
e 6 may ector, pi		20a, METHOD OF DISPOSITION t X Burlal 2 Cremation 3 Remo	val from State	20b. PLACE A cemetery, cre	AND DATE OF matory or oth	er plage)	(Name of		DATE 20c. LO	CATION —	City or Town, Stata			
direct		4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LICE	ENCEE	ft.	Line					adne	sburg Md.			
death. Pag tuneral dii I. examiner		L. STANLE ST. TONETHE SERVICE BO	1/ -				lor's		neral Se	rvic	е			
_ @ 72		Jamanah 1	HEIRE SCOR			225	Miss	our	i Ave.,	N.W.	20011			
d in by the or remove		23. PART I. Entar the diseases, or contains abook, or heart failure. L	omplications that	ceused tha de	ath. Do no	ot enter tha	mode of dyl	ing, suci	h as cardiac or respi	ratory arr	est, Approximate			
filled from the m	1 1	Interval between												
within 24 prietely fille cremation, rent, the		IMMEDIATE CAUSE (Final disease or condition reaulting in death)  Acute Mys carcleal infantial in												
B 6 - 6			DUE TO	OR AS A CONSEC	DUENCE (O/)		0 01		. 42					
entincate be executed in physician and congiene prior to burial, other traumatic ex	No.	Sequentially list conditione,	DHE TO	OR AS A CONSEC	WILL OF	C	arcu	ON	yo panny					
ysician prior to	CATION	If any, laading to immediata cause. Enter UNDERLYING	002.10	Coron	0141	$\alpha$	thorn	oril)	ovie		i			
phy ene p	띹	CAUSE (Disease or Injury that Initiated events	DUE TO	OR AS A CONSEC	DUENCE OF	:								
Hygi	ERTIFI	resulting in death) LAST												
the attending phy Mental Hygiene I Mental Hygiene I Jury, or other	2	PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a, WAS AN AUTOPSY 24b, WERE AUTOPSY FINDIN												
law requires that the oear as been signed by the att bept, of Health and Menta 23 shows any injury,	MEDICAL	Chronie ohet						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO						
requires that the een signed by the of Health and I shows any In		- Harris (	3) pef	lecció c	noncu	10 6	Lan	uas	1 🗆 YES 2	OF DEATH?				
shows	Σ	atherosis (	3) 14	the tile	15 0	urea	re				t 🗌 YES 2 🗍 NO			
9 4 -		25. WAS CASE REFERRED TO MEDICAL				24	S. PLACE OF O	FATU (OL	Total and					
	SIC	EXAMINER?	HOSPITAL:	FR/Outpetlant 3		OTHER:								
certific de de de de de de de de de de de de de	PHY	27. MANNER OF DEATH	28e. DATE OF	INJURY	28b. TIME	OF 28c.	INJURY AT	siderice	e Other (Specify)  28d. DESCRIBE HOW II	NJURY OCC	CUREO			
fler this c eath with marked,	ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Da	ly, Year)	INJU		WORK? YES 2	NO						
Afte deal	8	3 Suicide 8 Could not be	28a. PLACE Of	INJURY — At hor	me, tarm, str	reet, tactory, o	offica		28t. LOCATION (Street )		or Rural Route Number,			
S afte	쁘	4 Homicide determined	ounding, (	(Opecity)					City or Town, State)					
FUCKTIAL OR ALLEMUNING PHYSICIAN: IT FUNERAL DIRECTOR: After this certificate within 72 hours after death with the State TANT: If Hem 28 is marked, or Ner	PLE	29a. CERTIFIER (Check only	IAN: To the best of	my knowledge, de	nth occurred	at the time,	data and placa,	and dua	to the cause(a) and mar	mer as state	ed.			
ERAL in 72	<b>S</b>										e cause(a) and manner as stated.			
THE FUNER filed within PORTANT:	E CO	29b. SIGNATURE AND TITLE OF CERTIFIER	r 2				29c. LICE	NSE NUM	IBER	29d, DATE	E SIGNED (Month, Day, Year)			
M Filed	100	121 du	itasi				DS	242	70		2-25-93			
1	2	30. NAME AND AODRESS OF PERSON WHO			1 27) (Type, F	Print)	3/32							
0	)	RAVINDER A	K. Kus	TAG1			Cheves	le	udaver i	17.8	1			
		MAR 1 9 1993	32. REGISTINA	PANTALON-	Randa	22	- SEVILA	J		110				
		MAR 1 9 1993	Juna	A traffic fathers										

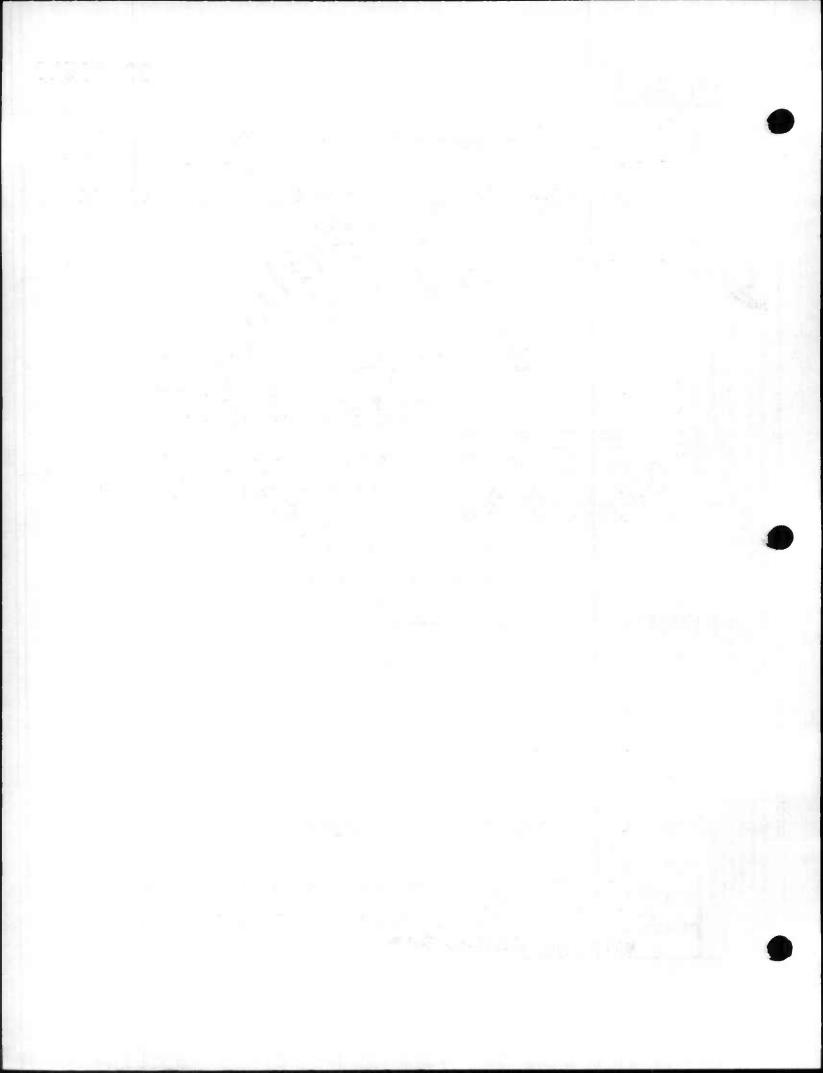


BALTIMORE, MARYLAND 21215-0026

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.  IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	

iff. Pages 1, 2, 3 should

	FOR 1 - STATE REGISTRAR	STATE OF N	MARYLAND (	/ DEPAR	RTMEN'	T OF H	HEALTH DEA	AND	MENTA	L HYGIEN	VE .	93	09549	
	1. DECOMENT'S NAME (First, Middle,	Last)							2. DATE	OF DEATH	DAY.		3. TIME OF DEATH	
	. Charles_	Lewis Wood	d						Mario	h 19,	1993	YEAR	7:30- A M	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. In		IF UNDER	DAYS	IF UNDE	R 24 HRS.				8. BIFTHE		
	578-12-1164	1 <b>½</b> M 2 □ F	92.	YRS.	MONTHS	DATE	HOURS	Merry.	10	- 31	-1900	West	t Virginia	
œ	9a. FACILITY NAME (If not institution,				All Property	- 41	OR LOCAT		EATH		Sc. COU	NTY OF DE	EATH	
<u>ō</u>	Anne Arundel Me		er			Anno	ipoli	5		Anne			Arundel	
DIRECTOR	10a. STATE 10b. CO	DUNTY		10c, CIT	Y, TOWN						-		10d. INSIDE CITY	
2	MD Ann	re Arundel	rundel Annapolis										LIMITS?	
34	100. STREET AND NUMBER	2 0. 1				101	. ZIP COD						HAT COUNTRY?	
FUNERAL	1104 Mainsail							21403					States	
FU	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDEN FORCES? 1	YES 2	RMED	13.	WAS DEC	ENDENT	OF HISPA an, Maxic	NIC ORIGI en, Puerto	N? (Specify Ye Ricen, etc.)	e or No-	14. RACE Black,	- American Indian, White, atc.	
B₹	3 Wildowed 4 Divorced	IF YES, GIVE W	WAR OR DATES	1 TYES	2 (1)(40	ly:			Specify	white				
COMPLETED	15. DECEDENT'S (Specify only highest	B EDUCATION	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working								JSINESS/INC	USTRY		
9	Elementary/Secondary (0-12)	College (1-4 or 8		B. Do NOT U	se retired.)	during me	AST OF WORK	ing						
MP		2	I	isura	nce	Brok			-	Insura				
	17. FATHER'S NAME (First, Middle, Las.  James M. Wood	st)					16. MOT			Middle, Malder				
BE	19a. INFORMANT'S NAME (Type/Print)	1		Db. 84 A 10 10 10	400000	0. (0				t N. 1				
5	Alyce Wood		"	110	4 Ma	insa insa	il. D	MINO	Au	nanal	wn, State, Zip	Code)	und 21403	
	20a. METHOD OF DISPOSITION		20b. PLACE			_				E 20c. L(				
	XIX Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific		4.000.040.00.00		46 -4- 6			03-2	1					
	21. SIGNATURE OF PUNERAL SERVI	CE LICENSES	10000	200071	22.	NAME A	ND ADDRE	ESS OF FA	CILITY	John A	A Tai	IP OH	laryland Funeral Hon	
	Heffay X	Tayla			14	7 Du	ke o	h Gl	ouce	ston S	St. A	mana	elis, MD	
	23. PART I/Enter the diseases shock, or heert fell IMMEDIATE CAUSE (Fine)	, or complications tha lure. List only one ceu	t coused the d	used the death. Do not enter the mode of dylon, such as cardiac or resolveto								Interval Between Onset and Death		
	disease or condition resulting in death)	a. POS	PIPOTO	OLY SOURCE O	AL	255	-							
NO	Sequentially list conditions,	PN PN	OR AS A CONSE	TOLY ALLUST  NSEQUENCE OF):  N/A / SSPSIS										
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING		(0		. ,.									
H	CAUSE (Disease or injury that initiated events	DUE TO	(OR AS A CONSE	OUENCE O	F):									
E	resulting in death) LAST	d												
	PART II. Other algnificent cond	ditions contributing to	deeth but not	resulting	In the ur	nderlyin	n cause	given in	Part I	24a, WAS A	VALITOREV	245	WERE AUTOPSY FINDINGS	
PHYSICIAN: MEDICAL										PERFO	RMED?	- 3	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
E I										1 TYES	2 1000		OF DEATH?	
2									_				1 TES 2 NO	
IAP	25. WAS CASE REFERRED TO MEDIC					26. Pt	ACE OF D	DEATH (Ch	eck only o	ne)				
SIC	EXAMINER?	HOSPITAL:	ER/Outpatlant	3 DOA	OTHEI		6 5 R	aaldenca	6 Oth	r (Specify)				
E	27. MANNER OF DEATH	28a. DATE OF (Month, D	INJURY ev. Year)	28b. TIN	_	28c. INJ				SCRIBE HOW	INJURY OCC	CURED		
BY	1 Natural 5 Pending 2 Accident Investigs	and the same of th			М		YES 2	NO						
	3 Suicide 8 Could no	building,	FINJURY — At he atc. (Specify)	ome, farm,	street, fac	tory, offic			281. LOC	CATION (Street or Town, State	and Number	or Rural Ro	oute Number,	
E														
COMPLETED		PHYSICIAN: To the best of												
Ö	2 MEDICAL EXA	AMINER: On the basis of a	xemination and/or	Investigation	on, in my o	opinion, d	leeth occu	red at the	time, deta	and place, a	nd dua to th	e cause(s)	and manner as stated.	
BE	296. SIGNATURE AND TITLE OF CER	TIFIER	0.11				29c. LIC	ENSE NUI	WBER		29d. DATI	SIGNED (	Month, Day, Year)	
5	30 NAME AND ADDRESS OF DESCRIPTION	N WHO COURT FEET A	ンバナ	AMI	Gran	JM	P	416	48		1 3	119	193	
	30. NAME AND ADDRESS OF PERSO	HOG-SW /	SE OF DEATH (ITE	A		2.0				1.1.	,			
	31. DATE FILED (Month, Day, Year)		R'S SIGNATURE		MA	NOM	5,1	W/S	2	140	/			
ļ	****	1993 guha	R'S SIGNATURE	Brides	4									
	עוחוי ט ט	1333		4										



31. DATE FILED (Month, Day, Year)

MAR 08

1993

32. REGISTRAR'S SIGNATURE

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH WAXXXX WAGONER MARCUS MONTH ()3 03 93 SAR PM EUGENE 1:35 A. SOCIAL SECURITY NUMBER 5, SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 10/5/1960 DAYS HOURS 1 M 2 | F 212-72-6685A 32 YRS. D.C. 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH Oc. COUNTY OF OEATH DIRECTOR frederick memorial hospital FREDERICK FREDERICK RESIDENCE OF DECEDENT 10a. STATE 10h. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Frederick Frederick 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER INC ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 19 West Seventh Street 21701 U.S.A. retained by the hospital or attending physician. burial-tran 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, atc. 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuban, Maxican, Puerto Rican, etc.) BALTIMORE, MARYLAND 21215-0020 FDRCES? 1 YES 2
IF YES, GIVE WAR DR DATES 2 X NO 1 Never Married 2 Married BY Specify: 1 TYES 2 X NO 3 Widowed 4 Divorced use as the White COMPLETED 15. OECEDENT'S EQUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) (Specify only highest grade comp detached for Elementary/Secondary (0-12) College (1-4 or 5+) 10 years None/Disabled 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) å 7 Paula Rippo BE George Dana Wagoner notified director, page 5 should 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Paula R. Wagoner West Seventh Street Frederick, Maryland 21701 hours after death. Page 6 may be pe 20g. METHOO OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Resthaven Memorial Gardens 3/6 Frederick, Maryland 21. SIGNATURE OF FUNDBAL SERVICE examiner 22. NAME AND ADDRESS OF FACILITY 0 ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. n by the fi 1201 NORTH MARKET ST. FREDERICK, MD medical filled in by t 23. PART I. Enter the di Enter the diseases, or complications that caused the dark. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each list. Approximata Interval Between 6 IMMEDIATE CAUSE (Final Onset and Death event, the disease or condition neumonia completely resulting in death) executed within DIVISION OF VITAL RECORDS, P.O. BOX 68760, DUE TO (OR AS A CONSEDUENCE OF): to burial. traumatic CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): attending physician are if any, leading to immediate cause. Enter UNDERLYING certificate CAUSE (Disease or Injury other DUE TO (OR AS A CONSEDUENCE DF): that initiated events resulting in death) LAST 20 the atten PART II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS Signed by the AVAILABLE PRIOR TO fatty AUR COMPLETION OF CAUSE 1 X YES 2 ND OF DEATH? Shows 2 Seizelle disorder 1 X YES 2 NO been 6 The law r has be Dept. PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

1 YES 2 NO 26. PLACE OF DEATH (Check only one) Item certificate h IE HOSPITAL OR ATTENDING PHYSICIAN: The EUNERAL DIRECTOR: After this certificate ad within 72 hours after death with the State NATANT: If Item 28 is marked, or Item HOSPITAL:
1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 Nursing Ho me 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE DF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26b. TIME OF 26d, DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: I 2 X MEDICAL EXAMINER: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(a) and manner as stated. Per RED TR 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE O.C.M.E ▶ 03- 04- 1993 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 PENN STREET BALTIMORE, MARYLAND 21201 DONALD G. WRIGHT M.D.

OHMH-18 Rev 1/89

(	1	ermt Paperer a no	A CONTRACTOR	
BALTIMORE, MARYLAND 21215-0020	s after death. Page 6 may be retained by the hospital or atternment or atternment.	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burnal manner permit.	emoval.	dical examiner must be notified at once.
UP VITAL RECORDS, P.O. BOX 68760,	PHYSICIAN: The law requires that the death certificate be executed within 24 frous after death. Page 6 may be retained by the hospital or attending	this certificate has been signed by the attending physician and completely filled in	with the State Dept. of Hearth and Mental Hygiene prior to bunal, cremation, or removal.	ked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BY

COMPLETED

BE

CERTIFICATION

PHYSICIAN: MEDICAL

BY

COMPLETED

BE

0

DIRECTOR: After the hours after death with them 28 is mark

TO THE HOSPITAL OR AT TO THE FUNERAL DIRECT be filed within 72 hours a IMPORTANT: If item 2

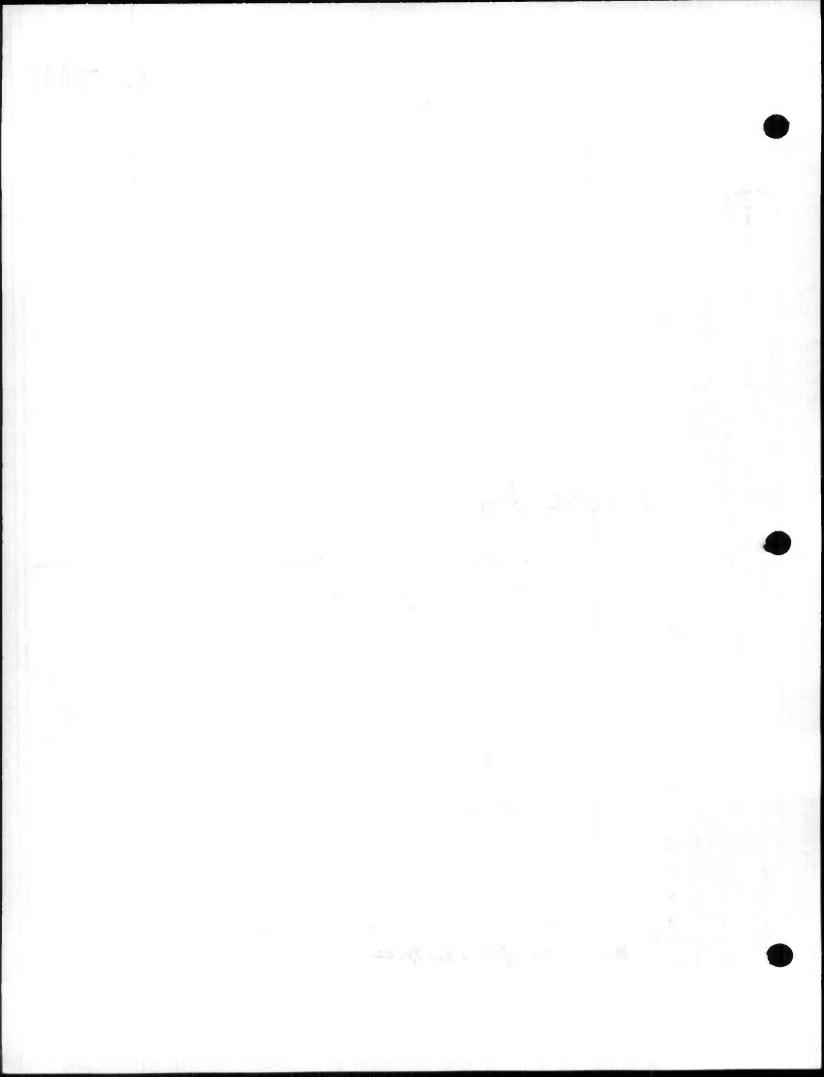
REG. NO 2. DATE OF DEATH
March 4, 1993 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH Allen Monroe WARFIELD YEAR 6:50 PM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign Dec. 26, 214-16-3729 1 XM 2 | F DAYS 77 1915 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN Frederick Memorial Hospital DIRECTOR Frederick Frederick RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Frederick Frederick XX YES 2 NO FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 904 Walnut Street 21702 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1XX YES 2 NO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: IF YES, GIVE WAR OR DATES 1942-1945 3 X Widowed 4 Divorced So White 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KINO OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Refrigeration / Repair 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Charles Warfield Annie Ridgely 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earle L. Arnold 906 Walnut Street, Frederick, Md. 21702 20a METHOD OF DISPOSITION

1 Mariel 2 Cremation 3 Removel from State
4 Donation 5 Other (Specify) DATE 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of Resthaven Memorial Gardens Mar 8,1993 Frederick, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Keeney and Basford P.A. Funeral Home MO0255 106 East Church St., Frederick, Md. 21701 23. PART i. Enter the diseases, or complications that caused the desth. Do not enter the mode of dying, such as cardiac or reapiratory arrest, abock, or heart fallure. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Final DUE TO (OR AS A CONSEQUENCE OF): disease or condition Ventrerular resulting in death) 10 min DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if sny, lesding to immediate csuse. Enter UNDERLYING CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in desth) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? PERFORMED? 1 TYES 2 NO 1 TYES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA OTHER:
4 □ Nursing Nome 5 □ Residence 6 □ Other (Specify) 1 - YES 2 - NO 28s. OATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATN 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO 2 Accident 3 Suicide 26a. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c, LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Michael S. Newford MD

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 017601 93 RUDWAN. HARP MEDICAL CTR MIDDLETONY M.D

1993 Julia Lavidson-Randale



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		FOR		
- 1	-	STATE	DA	_

	FOR STATE REGISTRAR		STATE OF I		/ DEPAR						HYGIEN REG. NO.	E 9,	3 1	19552		
	1. DECEDENT'S NAME (First,	Middle, Last)								2. DATE (				3. TIME OF DEATH		
•	DWIGHT (	MER I	WAGONER,	SR.						March	22,	199	YEAR 2	1:40 am. M		
	4. SOCIAL SECURITY NUMB	BER	5. SEX	5. SEX 8. AGE (In yrs. ias		est birthday) IF UNDER 1 YEAR			AR IF UNDER 24 HRS.		F BIRTH			LACE (State or Foreign		
1	217-16-4323	1 🔯 M 2 🗌 F	XM2 □ F 9]		MONTHS	DAYS	HOURS	MIN.		1901		Country)	Carolina			
1	9e. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LO			OR LOCATIO	ON OF D		1901	9c. COUNT				
Œ	Madonna Hei			-	svil				Harf							
8	RESIDENCE OF DECEDENT					1										
DIRECTOR	10a, STATE 10b, COUNTY				1117	Y, TOWN		TION						10d. INSIDE CITY LIMITS?		
	Maryland	Harf	ord		F	alls	ton							1 TES 2 NO		
AL	10e. STREET AND NUMBER	10f. ZIP CODE							N OF WI	VHAT COUNTRY?						
E	2101 Harfor	rd Rd.					2	1047				U.S.A.				
FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S.	ARMED						(Specify Yes	or No- 1		- American Indian,		
ВУР	1 Never Married 2 🔁 3 Widowed 4 Divo	1.0	IF YES, GIVE V	YES 27	Σίνο			2. MO	n, Mexica Specif	sn, Puerto Ri ly:	can, etc.)		Specify	k, White, etc.		
	3   Widowed 4   Divo	rced						7.7.				wl	nite			
Ē.	15. DEC (Specify only	EDENT'S EDUC y highest grade	CATION completed)		DECEDENT'S	work done			ø	16b.	KIND OF BUS	INESS/INDU	STRY			
2	Elementary/Secondary (0	1-12)	College (1-4 or 5	+)	Ha. Do NOT u					10-		-1.5	/ 7			
COMPLETED	6			Ca	rpent	er& 1	rarn	_					' Ag	riculture		
	17. FATHER'S NAME (First, M										ddle, Meiden	-				
BE	Jereman Her	_	agoner				_	Aur			(nmn) Hash					
2	Dwight Wagor		Tr							Hill,	-	21050	_ ′			
- i	20a. METHOD OF DISPOSITI		) L 0						20 C							
20s. METHOD OF DISPOSITION  1 K Burlel 2 Cremation 3 Removel from State  4 Donatton 5 Other (Specify)  20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, cereatory or other place).  BEL AIT MEMORIAL Gardens 3/25/93 Bel Air, M.								aryland								
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE    22. NAME AND ADDRESS OF FACILITY															
	Housers	KI	Velo	mon	111							neral ngdon				
	23. PART i. Enter the di	seases, or o	complications the	t caused the	death. Do	not enter	tha me	de of dyl	ng, suc	h as card	ac or respi	ratory arres	ıt,	Approximate		
	IMMEDIATE CAUSE (Fin						,	1				Interval Between Onset and Death				
	disease or condition resulting in death)	<b>→</b>		CARDI	o Res	pun	ton	) NI	res	+						
	rosattily in acatily		DUE TO	(OR AS A CONS	EQUENCE O	F):										
Z	Demertia															
월	Sequentially list conditi if any, leading to immed	diate	^		A CONSEQUENCE OF):											
할	cause. Enter UNDERLY! CAUSE (Disease or inju		C	- 1-17		7										
CERTIFICATION	that initiated events resulting in death) LAS	т П	OUE TO	(OR AS A CONS	EQUENCE O	F):										
<b>5</b>	133		d													
A F	PART II. Other significa	nt condition	s contributing to	death but not	resuiting	in the un	derlyin	g cause g	iven in	Part i.	24a. WAS AN	AUTOPSY	24b. 1	WERE AUTOPSY FINDINGS		
3										_ [	PERFOR			MAILABLE PRIOR TO COMPLETION OF CAUSE		
											1 1 123 2	_ NO		OF DEATH?		
2										- 1				I NES 2 NO		
PHYSICIAN: MEDICA	25. WAS CASE REFERRED TO	O MEDICAL					26. P	LACE OF D	EATH (Ch	neck only one	,					
SIC	EXAMINER?		HOSPITAL:	ER/Outpatient	3 🗆 DOA	OTHER 4   Nur	₹:			6 Other		acc.	tid	CARE Hous		
Ŧ	27. MANNER OF DEATH		28a. DATE OF	INJURY	28b. T/A	E OF	28c. IN.	JURY AT	SIDEFICE			JURY OCCU		2 14 43		
		Pending	(Month, E	lay, Year)	IN.	JURY M		ORK? YES 2 [	NO							
BÁ	2 Podelde	Could not be	28a. PLACE O	F INJURY — AL	home, farm,	street, fact				281. LOCA	FION (Street a	nd Number or	Bural Ro	ute Number,		
COMPLETED		determined	building,	etc. (Specify)						City o	Town, State)					
ا پر	29a. CERTIFIER 1 CERT	IFYING PHYSI	CIAN: To the best of	my knowledge	death accu-	and at the a	ime das	and alea-	and A.	to the en	a(a) c=d =	DAR 80 00:0: 1				
M M														and manner ee stated.		
	29b. SIGNATURE AND TITLE															
8	NI	10 11)	Art	~				29c. LICE	20 I	DO		DATE S	SIGNED (	Month, Day, Year)		
2	30. NAME AND ADDRESS OF	F PERSON WH	O COMPLETED CALL	SE OF DEATH AT	FM 27) /3	Drine)		UC	270	J		/		117		
	Harris Constitution of the				am ary (1990)	, , , , , , ,										

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit perm be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. **BALTIMORE, MARYLAND 21215-0020** 

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

31. DATE FILED (Month, Day, Year)
WAR 23 93

32. REGISTRADE SIGNATURE PONDESSE.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

DHMH-16 Rev 1/89

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit per be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	REGISTRAR				ICALE					REG. NO.			
- 8	1. DECEDENT'S NAME (First, Middle, Last)  Ethel Ma:	rie Wer	1				MONTH	MONTH DAY YEAR			3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER											4 A.M. M	
Į.	218-01-9161	Service (17 year of the control of t							PLACE (State or Foreign y) 7] and				
- 5	9a. FACILITY NAME (If not institution, give s			9b. CITY.	ITY, TOWN OR LOCATION OF DE						COUNTY OF DEATH		
œ	2107 Cameron Cour							047					
8	RESIDENCE OF DECEDENT				DeT	Ai	Ľ		21	015	Har	Torc	d County
DIRECTOR	10a. STATE 10b. COUNTY	Y		10c. CIT	Y, TOWN O	R LOCAT	TION						10d. INSIDE CITY
뜻	Maryland Harfo	77	1 "	Bel	A =				010	4 5	- 1	LIMITS?	
	10e. STREET AND NUMBER	<u>y</u>		Der		. ZIP COD						1 YES 2 NO	
FUNERAL		L				107	. ZIP COD	-	10g. CITIZEN OF WHA				
빌	2107 Cameron Cour							2101	4			S.A	
2	11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEDEN FORCES? 1							IIC ORIGIN?	(Specify Yes	or No-	14. RACE Black	— American Indian, i., White, etc.
BY	3 N Widowed 4 Divorced	IF YES, GIVE W			1	YES	2 NO	Specify	r:			Specif	My:
												Whi	ite
回	15. DECEDENT'S EDU (Specify only highest grade		16a	Give kind of	USUAL OC	CUPATIO	ON st of working	107	16b.	KIND OF BUS	SINESS/IND	USTRY	-
iu	Elementary/Secondary (0-12)	College (1-4 or 5	+)	ille. Do NOT u	se retired.)								
<u>a</u>	7			House	ewif e	)				Homer	maker	•	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTI	HER'S NAI	ME (First, M	ddle, Meiden	Sumame)	·	
BE	James Adam	n Downs	3					Ma	abel	Gra	ce	King	7
	198. INFORMANT'S NAME (Type/Pri	hter515	0168	19b. MAJLING	ADDRESS	(Street a	nd Number	or Rural R	Route Numbe	r, City or Town			
임	Mrs. Sandra J. Di	ick		2107	Came	mon	Com	rt. E	A Fas	ir. Ma	e frm e	nd 2	21015
	20a. METHOD OF DISPOSITION		20b. PLA	CE AND DATE				. 0 4 1	DATE		CATION -		
	1 Donation 5 Other (Specify)	oval from State	cemetery	crematory or o	ther place)	th		1/20	. 1				
	1 M Burdel 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify) Gardens of Faith 3/as/93 Baltimore, Maryland  21. SIGNATURE OF FUNERAL SERVICE LICENSEE JOSEPh Wa Foster 22. NAME AND ADDRESS OF FACILITY Foster Funeral Home								Ucme				
		Den Frate		00001		50 V	Vest	Broa	dwav	& W1	lliam	s St	rest.
										& Wi			1 660
	23. PART i. Enter the diseases, pr	complications the	t caused the	death. Do	not enter	the mo	de of dy	ing, suct	h as cardi	ac or respi	ratory arr	est,	Approximata
	shock, or heart failure.	List only one cau	se on each	line.									Onset and Death
iMMEDIATE CAUSE (Final disease or condition resulting in death)  a.													
								1	rt				
	resulting in death)	a. DUE TO	OR AS A COM	SEQUENCE O	/mon	my	_/-	116	st				
_	resulting in death)	DUE TO	OR AS A CON	NSEQUENCE O	/moni	my	7	tru	xt	RIL			
NOI	Sequentially list conditions,	DUE TO	OR AS A CON	NSEQUENCE O	/moni Fi: Chron	nit	J-	tru	the dive	Polmor	ny Pe	. 200	e year
ATION		b. En	OR AS A COM	SEQUENCE O	Chron	nit	Oh	fre	y've	Plan	ny Pe	. 400	e year
FICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	b En	OR AS A COM	ISEQUENCE O	Chron Pi Sant	nit	Oh	fre	st live	Pelman	ny Pe	. 400	e year
RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	b En	OR AS A COM	ISEQUENCE O	Chron Pi Sant	nit	Oh	fre	- Hive	Plan	ort Ve	` sea	e year
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	b En	OR AS A COM	ISEQUENCE O	Chron Pi Sant	nit	Oh	fre	- Nive	Plan	ny Pe	. 7-00	e your
	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	b. EN DUE TO	OR AS A COM	NSEQUENCE O	Chra Fi: Sart Fi:	F	Oh.	tru	-Nive	24s. WAS AN	AUTOPSY		Y P AV
ICAL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant condition	b. EV OUE TO C. DUE TO	OR AS A COM	NSEQUENCE O	Chra Fi: Sart Fi:	F	Oh.	tru	- N've	24a. WAS AN PERFOR	AUTOPSY IMED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE
EDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. EV OUE TO C. DUE TO	OR AS A COM	NSEQUENCE O	Chra Fi: Sart Fi:	F	Oh.	tru	- N've	24s. WAS AN	AUTOPSY IMED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
EDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant condition	b. EV OUE TO C. DUE TO	OR AS A COM	NSEQUENCE O	Chra Fi: Sart Fi:	F	Oh.	tru	- N've	24a. WAS AN PERFOR	AUTOPSY IMED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE
EDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant condition  A (2 A P)	b. EV OUE TO C. DUE TO	OR AS A COM	NSEQUENCE O	Chra Fi: Sart Fi:	derlying	Ohy ailu g cause g	fre me	Part i.	24s. WAS AN PERFOR 1 YES 2	AUTOPSY IMED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
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PHYSICIAN: MEDICAL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant condition  A (2 A P)  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 X YES 2 NO  27. MANNER OF DEATH	DUE TO  d. DUE TO  HOSPITAL:	(OR AS A COM	ISEQUENCE O	Chroners:	derlying  26. PL  ising Hom  28c. INJI  WO	ACE OF D  ACE OF D  SER RE  URY AT  RK?	given in i	Part i.	24e. WAS AN PERFOR	AUTOPSY AMED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant condition  A (2 A P)  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 X YES 2 NO	DUE TO  C. DUE TO  d	(OR AS A CON  GENOUTPHIER  ER/Outpatien  INJURY  ey, Year)	ISEQUENCE O	Chroners Chr	derlying  26. PL  i: iling Hom  28c. [NJI] WO  1 □ Y	ACE OF D  ACE OF D  THE STATE OF THE STATE O	given in i	Part i.	24a. WAS AN PERFOR	AUTOPSY AMED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant condition  A 2 AP 2  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 X YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation 3 Suicide 6 Could not be	DUE TO  d.  HOSPITAL: 1   Inpetient 2    28e. PLACE OF	(OR AS A COM	ISEQUENCE O	Chroners Chr	derlying  26. PL  i: iling Hom  28c. [NJI] WO  1 □ Y	ACE OF D  ACE OF D  THE STATE OF THE STATE O	given in i	Part i.  Part i.  Dock only one 28d. DESC	24a, WAS AN PERFOR	AUTOPSY IMED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant condition  A (2 A P )  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 X YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending investigation	DUE TO  d.  HOSPITAL: 1   Inpetient 2    28e. PLACE OF	(OR AS A CON  GO	ISEQUENCE O	Chroners Chr	derlying  26. PL  i: iling Hom  28c. [NJI] WO  1 □ Y	ACE OF D  ACE OF D  THE STATE OF THE STATE O	given in i	Part i.  Part i.  Dock only one  8  Other  28d. DESC	24a. WAS AN PERFOR 1   YES 2 (Specify) RRBE HOW III	AUTOPSY IMED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMMILETION OF CAUSE OF DEATH?  1 YES 2 NO
BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant condition  A 2 A P 2  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 DX YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending investigation  3 Suicide 6 Could not be determined	DUE TO  d.  HOSPITAL: 1   Inpetient 2    25e. DATE OF (Month, D)  28e. PLACE O building.	(OR AS A CON  GENOUTPATION  GENOUTPATION  FINJURY  A Stc. (Specify)	ot resulting  R 3 DOA  28b. Till IN.	Chroners:  Chroners:  Others:	26. PL	ACE OF D  ACE OF D  UNY AT  RK7  CES 2	given in i	Part i.  Bick only one Bill Other 28d. DESC	24a. WAS AN PERFOR 1 YES 2  (Specify)  RIBE HOW III  TION (Street a Town, State)	AUTOPSY IMMED?  CENO  NJURY OCC	CURED or Flural R	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMMILETION OF CAUSE OF DEATH?  1 YES 2 NO
BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant condition  A 2 A P 2  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 D YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending investigation 3 Suicide 6 Could not be determined  296. CERTIFIER (Check only)  1 CERTIFYING PHYSE	DUE TO  C. DUE TO  d. BE CONTRIBUTING TO  HOSPITAL:  1 Inpetient 2  28e. DATE OF (Month, D)  28e. PLACE O building.	(OR AS A CON  GENOUTPATION  INJURY  HOW, Year)  FINJURY — A  atc. (Specify)  my knowledge	ot resulting  at home, farm, so, death occurrence	Chroners:  Chroners:  OTHER  4   Nurselle OF    JURY M    attreet, factor	26. PLE: sing Home 28c. INJI vory, office	ACE OF D  ACE OF D  OF S TO Re  URY AT  RK7  FKS 2 [	given in i	Part i.  Part i.  Bick only one  Bill Other  28d. DESC  City or	24a. WAS AN PERFOR 1   YES 2 (Specify)   RIBE HOW III   TON (Street a Town, State)	AUTOPSY MMED?  CCNO  NJURY OCC  and Number	24b. CURED  or Rural R	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant condition  A (2 A P )  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 X YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation 2 Accident Investigation of Could not be determined determined  29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE	DUE TO  C. DUE TO  d. Ba contributing to  HOSPITAL:  1 Inpetient 2  28a. DATE OF (Month, D)  28b. PLACE OF building,  CIAN: To the best of a:	(OR AS A CON  GENOUTPATION  INJURY  HOW, Year)  FINJURY — A  atc. (Specify)  my knowledge	ot resulting  at home, farm, so, death occurrence	Chroners:  Chroners:  OTHER  4   Nurselle OF    JURY M    attreet, factor	26. PLE: sing Home 28c. INJI vory, office	ACE OF D  ACE OF D  S M Re URY AT RK7 (ES 2 [	given in i	Part i.  B Other  281. LOCA City or  to the caus	24a. WAS AN PERFOR 1   YES 2 (Specify)   RIBE HOW III   TON (Street a Town, State)	AUTOPSY IMMED?  CENO  NJURY Occ  and Number	cure or Aural A	WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  Route Number;
BE COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant condition  A 2 A P 2  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 D YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending investigation 3 Suicide 6 Could not be determined  296. CERTIFIER (Check only)  1 CERTIFYING PHYSE	DUE TO  C. DUE TO  d. Ba contributing to  HOSPITAL:  1 Inpetient 2  28a. DATE OF (Month, D)  28b. PLACE OF building,  CIAN: To the best of a:	(OR AS A CON  GENOUTPATION  INJURY  HOW, Year)  FINJURY — A  atc. (Specify)  my knowledge	ot resulting  at home, farm, so, death occurrence	Chroners:  Chroners:  Chroners:  Chroners:  Chroners:  Chroners:  Chroners:  OTHER  4   Nurse  BE OF  JURY  M  M  Street, factor  ed at the tile  on, in my op	derlying  26. PL  1: ling Hom  28c. INJI  WO  1  Y  Pory, office  me, dete	ACE OF D  S TO RE  OF D  TREY  and place eath occur  29c. LICE	EATH (Che is idence is and due is not at the tense is not at the t	Part i.  sck only one,  B Other  28d. DESC  City of  to the cause time, date a	24a. WAS AN PERFOR 1   YES 2   (Specify)   RIBE HOW II   TION (Street a Town, State)   e(a) and man and place, an	AUTOPSY IMMED?  CENO  NJURY OCC  and Number  and estate  defined as state  defined as state  Autopsy	cure or Aural A	WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  Route Number,  and menner as stated.  (Month, Day, Year)
BE COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant condition  A 2 A P 2  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 X YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending investigation 3 Suicide 6 Could not be determined  296. CERTIFIER (Check only one) 2 MEDICAL EXAMINE  296. SIGNATURE AND TITLE OF CERTIFIES	DUE TO  C. DUE TO  d. Ba contributing to  HOSPITAL: 1 Inpetient 2 26a. DATE OF (Month, D) 26a. PLACE OF building,  CIAN: To the best of a:	COR AS A CON  GO	ot resulting  at 3 DOA  29b. TIM  thome, farm,  death occurr	Chroners:  Chroners:  Chroners:  Chroners:  Chroners:  Chroners:  Chroners:  OTHER  4   Nurse  BE OF  JURY  M  M  Street, factor  ed at the tile  on, in my op	derlying  26. PL  1: ling Hom  28c. INJI  WO  1  Y  Pory, office  me, dete	ACE OF D  S TO RE  OF D  TREY  and place eath occur  29c. LICE	EATH (Che is idence is and due is not at the tense is not at the t	Part i.  sck only one,  B Other  28d. DESC  City of  to the cause time, date a	24a. WAS AN PERFOR 1   YES 2   (Specify)   RIBE HOW II   TION (Street a Town, State)   e(a) and man and place, an	AUTOPSY IMMED?  CENO  NJURY OCC  and Number  and estate  defined as state  defined as state  Autopsy	cure or Aural A	WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  Route Number;
BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant condition  A 2 P PART II. Other significant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  Yes 2 NO  27. MANNER OF DEATH  1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined  29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER  30. NAME AND ADDRESS OF PERSON WH	DUE TO  DUE TO	(OR AS A COM  GO	ot resulting  ot a J DOA  28b. Tim (N)  ot home, farm, so, death occurrence for investigation invest	Chrone F):  OTHER 4   Nursele OF JURY M  street, factor on, in my op	26. PL I: sing Home Wood 1 Vory, office me, data pinion, do	ACE OF D  ACE OF D  S IN Re UNY AT RK7 /ES 2  and place, eath occur  29c. LICE AM 16	given in it	Part I.  Bock only one  B Other  28d. DESC  City or  to the caus time, date a	24a. WAS AN PERFOR 1 YES 2  (Specify)  RIBE HOW II  FION (Street a Town, State)	AUTOPSY IMMED?  CENO  NJURY OCC  and Number  as stated due to the  29d. DATI  M.a.	cured and a coupe of a	WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  Route Number,  and menner as stated.  (Month, Day, Year)
BE COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant condition  A 2 P PART II. Other significant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  Yes 2 NO  27. MANNER OF DEATH  1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined  29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER  30. NAME AND ADDRESS OF PERSON WH	DUE TO  DUE TO	(OR AS A COM  GO	ot resulting  ot a J DOA  28b. Tim (N)  ot home, farm, so, death occurrence for investigation invest	Chrone F):  OTHER 4   Nursele OF JURY M  street, factor on, in my op	26. PL I: sing Home Wood 1 Vory, office me, data pinion, do	ACE OF D  ACE OF D  S IN Re UNY AT RK7 /ES 2  and place, eath occur  29c. LICE AM 16	given in it	Part I.  Bock only one  B Other  28d. DESC  City or  to the caus time, date a	24a. WAS AN PERFOR 1 YES 2  (Specify)  RIBE HOW II  FION (Street a Town, State)	AUTOPSY IMMED?  CENO  NJURY OCC  and Number  as stated due to the  29d. DATI  M.a.	cured and a coupe of a	WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  Route Number,  and menner as stated.  (Month, Day, Year)
BE COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant condition  A 2 A P 2  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 X YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending investigation 3 Suicide 6 Could not be determined  296. CERTIFIER (Check only one) 2 MEDICAL EXAMINE  296. SIGNATURE AND TITLE OF CERTIFIES	DUE TO  DUE TO	(OR AS A COM  GO	ot resulting  ot a J DOA  28b. Tim (N)  ot home, farm, so, death occurrence for investigation invest	Chrone F):  OTHER 4   Nursele OF JURY M  street, factor on, in my op	26. PL I: sing Home Wood 1 Vory, office me, data pinion, do	ACE OF D  ACE OF D  S IN Re UNY AT RK7 /ES 2  and place, eath occur  29c. LICE AM 16	given in it	Part I.  Bock only one  B Other  28d. DESC  City or  to the caus time, date a	24a. WAS AN PERFOR 1 YES 2  (Specify)  RIBE HOW II  FION (Street a Town, State)	AUTOPSY IMMED?  CENO  NJURY OCC  and Number  as stated due to the  29d. DATI  M.a.	cured and a coupe of a	WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  Route Number,  and menner as stated.  (Month, Day, Year)

FOR

		1 - STATE REGISTRAR	OTALL OF MARTIER	CERTIF	ICATE OF	DEATH	MICHIA	REG. NO.	5			
		1. DECEDENT'S NAME (First, Ministration)	, 11		/		2. DATE	OF DEATN		3.	TIME OF DEATH	
		Louis Den	and Welmoth, Se.					3 23 93		EAR	409 M	
		4. SOCIAL SECURITY NUMBER		yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH	8.	BIRTHPL Country)	ACE (State or Foreign	
9		226-09-4863	1)C M 2 C F 7	YRS.	MONTHS DAYS	HOURS MIN.	10		16 V	irgi	nia	
nots		9e. FACILITY NAME (If not institution, give str	set and number)		96. CITY, TOWN	OR LOCATION OF D	EATH		9c. COUNTY			
AND DE	6	Neefard Memoria	Myseta		Name de Grace				New Jan A			
	DIRECTOR	RESIDENCE OF DECEDENT  10e. STATE 10b. COUNTY		10c. CITY, TOWN OR LOCATION								
			rford								d. INSIDE CITY LIMITS?	
		10e. STREET AND NUMBER			Churchy	111E			10- 0/7/75/		T COUNTRY?	
sit p	FUNERAL	7 Calvary Road			1	21028					II COUNTRY?	
215-0020 attending physiclan. se as the burial-transit	3	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U		13. WAS DE	Z 1 U Z O	NIC ORIGII	N? (Specify Yee		S.A.	American Indian	
DPhys burit		1 Never Married 2 Merried	FORCES? 1 X YES IF YES, GIVE WAR OR DATE		Il yes, s	pecify Cuben, Mexic S 25 NO Speci	an, Puerto	Rican, etc.)	S. 110	Black, V Specify:	American Indian, fhite, etc.	
15-0020 ending physic as the burial	BY	3 Widowed 4 Divorced	WW II			-XX	·y.			Whit	e	
r after	国	15. OECEDENT'S EDUC. (Specify only highest grade of	ATION 10 completed)	(Give kind of v	USUAL OCCUPATE	168	. KIND OF BUS	INESS/INDUS	TRY			
0 m 5	Ë	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	e retired.)							
AND 21 the hospital or detached for u	COMPLETED	12 17. FATNER'S NAME (First, Middle, Last)	_ 0   C	Civil Se	ervice		_	J. S. C				
			dilmath			18. MOTNER'S NA			•			
MARY retained by 5 should be notified at	BE	Robert Harrison W	TIHOUI	405 4444 1910	4000500 (0)	Laura and Number or Rural		Camper				
MAR retained 5 should notified	2	Mrs. Margaret Wil	moth	1							4000	
ay be		20e. METHOD OF DISPOSITION			FDISPOSITION IN	ad, Chur	CNV1		ATYLAN		1028	
TIMORE  1. Page 6 may be and director, pag		1 X Buriel 2 Cremetion 3 Removed A Donation 5 Other (Specify)	val from State camete	ery, crematory or of	thar place)	Gardens	1					
Page at dire	)	21. SIGNATURE OF FUNERAL SERVICE LICE	INSEE	ALL ME		NO ADDRESS OF FA		26 Be]	Air,	Mar	vland	
BALTIMORE, ter death. Page 6 may be the funeral director, page val.		* Kirsten Anu	1/1/0/0/01	hon	Tarr	ing-Carg	o Fur			P.A.		
BALTIMORE, Ins after death. Page 6 may be tenoral director, page 1 monoral.	-	23. PART i. Enter the diseases, or co	mails at lone that severed to	be death Don	Aben	deen, MD	210	001–339	99			
24 hours after filled in by th on, or remova		anock, or naert failure. L	ist only one cause on eecl	h line.	ot enter the mo	ode of dying, aud	on as cen	diac or reapir	atory srrest	9	Approximate Interval Batween	
fille ion,		iMMEDIATE CAUSE (Final disease or condition	Asten	Para Des	P.		.0-	10		•	Onset and Death	
ted within 24 to completely fille ial, cremation, event, the		disease or condition resulting in death)  a. Atternational technique of:  OUE TO (OR AS A CONSEQUENCE OF):										
	z	z									Í	
P.O. BOX 68  The certificate be executed and confing physician and confing physician prior to burish or other traumatic	ERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CO	ONSEQUENCE OF	ŋ:							
. BOX ficate be physician ne prior t	2	CAUSE (Disease or injury										
certificate nding physical Hygiene property or other to	Ë	that initiated events resulting in death) LAST	DUE TO (OR AS A CO	ONSEQUENCE OF	7):							
	E I	d.										
그 을 들 를		PART II. Other significant conditions	contributing to death but	not resulting i	n the underlyln	g ceuse given in	Part I.	24s. WAS AN			RE AUTOPSY FINDINGS	
OR that the phy lith and any	SICAL	Red	utes Mella	tus'				PERFORI		CO	MPLETION OF CAUSE	
w requires been signification of Health 3 shows	WE							/	•		DEATH?	
law re las bee Dept. o	AN:										7	
TA at at E	SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL: 1/		26. P	LACE OF OEATH (Ch	neck only or	16)				
> 4 = 0 5	> III	1 X YES 2 NO	1 Inpetient 2 DER/Outpetie	ent 3 DOA		ne 5 🗆 Residence	8 🗆 Othe	r (Specify)				
OF PHYSIC this cer with th	F	27. MANNER OF DEATN  1 Netural 5 Pending	(Month, Day, Year)	28b. TIME		JURY AT DRK?	28d, OES	SCRIBE NOW IN	JURY OCCUR	ED		
ON OING PHYS After this death with	₩	2 Accident Investigation	200 DI ACE OF IN HIDY	A11-1-1		YES 2 NO						
VISION ATTENDING ECTOR: After s after death		3 Suicide 8 Could not be 4 Nomicide determined	28e. PLACE OF INJURY — building, etc. (Specify)	At home, farm, s	treet, fectory, offic	20	28f. LOC City	ATION (Street ar or Town, State)	nd Number or I	Rural Flout	Number,	
DIVISION OR ATTENDING F DIRECTOR: After hours after death item 28 is mar	4	29e. CERTIFIER										
로 보었는	COMPL	(Check only	IAN: To the best of my knowled									
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: II	8	27	On the basis of examination e	nd/or investigation	n, in my opinion, o	leath occured at the	Ilme, date	and place, and	due to the co	use(s) en	d menner as stated.	
를 물 물 등	BE	296. SIGNATURE AND TITLE OF CERTIFICA	1 Leip 1	/-	nun	29c. LICENSE NUI	11 111			- /	onth, Day, Year)	
2 6 3 ₹	2	30. NAME AND ADDRESS OF PERSON WHO	FOUND TO THE PORT OF THE PORT			201	774	البو	1 3/2	3/9	2	
			COLFER M	H (ITEM 27) (Type,	20/3Z	To h	unes	X	,	.71	,	
		RICHARD J.  31. DATE FILEO (Magnin, Quy Year)		UDE		Na	ingl	e, Ma	2/0	005		
		MAR 24 93	982, REGISTRAR'S SIGNATI	and all								

OHMH-18 Rev 1/89

Alway I amen

FOR STATE

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

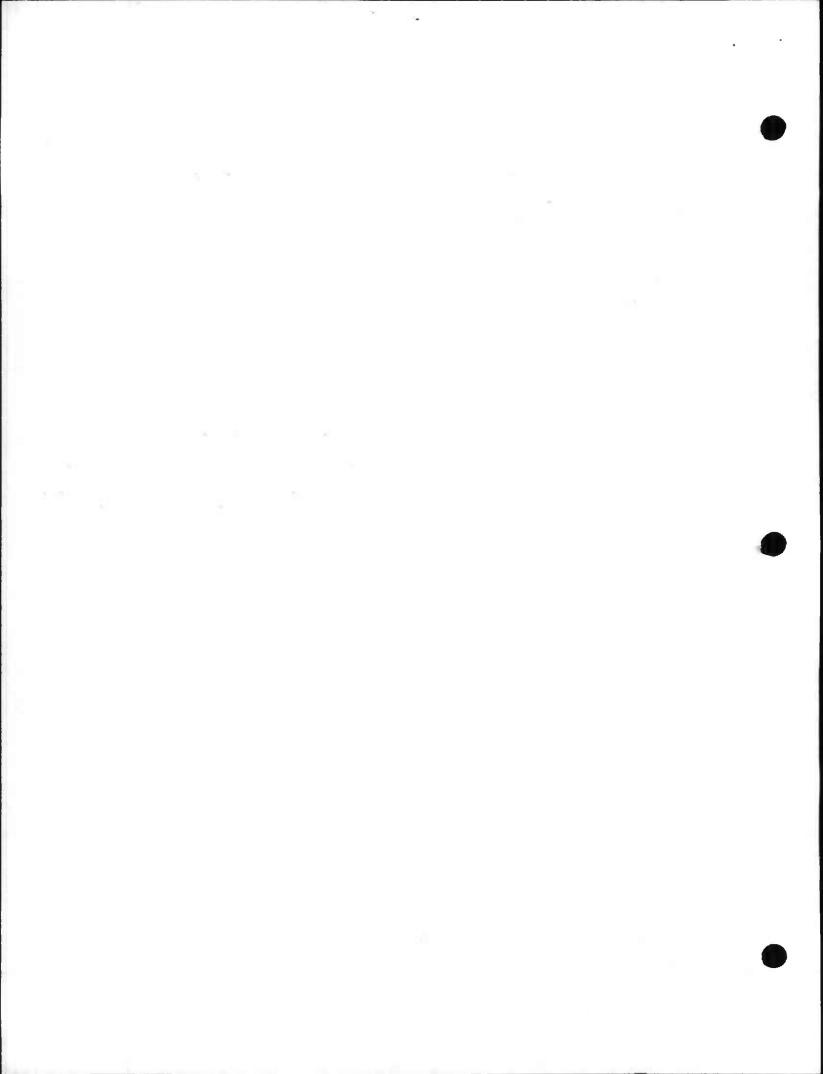
	REGISTRAR		CE	RTIF	ICATE C	F DEATH	REG. NO	).			
	1. DECEDENT'S NAME (First, Middle, Lest)						2. DATE OF DEATH			. TIME OF DEATH	
	CHARLES J	OHN WILLI	CK					5 1	YEAR   8	:30 A. M	
	4. SOCIAL SECURITY NUMBER		GE (In yrs. last	birthday)	IF UNDER 1 YE	R IF UNDER 24 HRS.	7. DATE OF BIFTTH	5		ACE (State or Foreign	
	219-01-6912	1 🔯 M 2 🗆 F		YRS.	MONTHS DAY		(Month, Day, Year)		Country)		
			83	1113.			Oct. 31,				
- 1	9a. FACILITY NAME (If not institution, give s				9b. CITY, TOV	N OR LOCATION OF D	EATH	9c. COU	INTY OF DEA	тн	
0	1805 Nuttal Ave.				Edo	ewood		1	Harfo	ord	
5	RESIDENCE OF DECEDENT										
DIRECTOR	10a. STATE 10b. COUNT				Y, TOWN OR LO			10d.			
0	Maryland Harf	ord		Ed	lgewood				1	LIMITS?	
A	10e, STREET AND NUMBER					10f. ZIP CODE		10g. CIT	IZEN OF WH	AT COUNTRY?	
BY FUNERAL	1805 Nuttal Avenu	e				21040		1	USA		
ᅙ	11. MARITAL STATUS	12, WAS DECEDENT EV	FR IN U.S. ARI	4ED	12 WAS		NIC ORIGIN7 (Specify Ye	a au Ma		- American Indian,	
正	1 Never Married 2 Married	FORCES? 1 1	YES 2 XX	0	If yes	, specify Cuban, Mexic	an, Puerto Rican, etc.)	15 OF 140—	Black,	- American Indian, White, etc.	
A	3 X Widowed 4 Divorced	IF YES, GIVE WAR O	DR DATES		1 🗆	rES 2 X NO Speci	ly:		Specify:	White	
ED	15. DECEDENT'S EDU	CATION	140. 050		1				•	MITTE	
쁘	(Specify only highest grade	completed)	(Gh	re kind of v	USUAL OCCUP work done during se retired.)	MOST of working	16b, KIND OF BU	ISINESS/IN	DUSTRY		
ا ت	Elementary/Secondary (0-12)	College (1-4 or 5+)	100								
Σ	8		M	echa	nic		Auto	Repa	airs		
COMPLET	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S N	ME (First, Middle, Meider	Sumame)			
BE (	John Paul 190. INFORMANT'S NAME (Type/Print)	Willi	ck			Marv		Κr	ell		
	19e. INFORMANT'S NAME (Type/Print)			MAJLING	ADDRESS (Str		Route Number, City or To				
2	Catherine Marlene	Moadows					ood, Md. 2				
	20a, METHOD OF DISPOSITION	readows			OF DISPOSITION				4011014110		
	1 N Burial 2 ☐ Cremation 3 ☐ Rem	oval from State	cemetery, crem	natory or o	ther place)	(Name of	DATE 20c. L	DCATION —	City or Town	i, State	
	4 Donation 6 Other (Specify)		Bel A	<u>ir M</u>	emoria	1 Gardens	3-29-93	B∈	el Air	, Md.	
	H. SIGNATURE OF FUNERAL SERVICE LIK	OAA A				AND ADDRESS OF F		T1	. 7		
	Darvois 19	1100 110	MA	177	7 10W	T Cokooby	Comas III	runer	TAL HO	me, P.A.	
	23. PART I. Enter the diseases, or	complications that are	rues	W 22	131	/ CORESDU	ry Rd., Ab	ingac	M, MO		
ŀ	shock, or heart failure.	List only one cause of	on each line.	itii. Do r	iot enter the	mode or dying, suc	n as cardiac or resp	eratory ar	rest,	Approximate Interval Between	
	IMMEDIATE CAUSE (Final	0 /	/	1	1-1	1	15			Onset and Death	
	disease or condition resulting in death)	· Willer	0200	ers	tip (a)	Iden Sal	ulas Hos	2000	0.		
		DUE TO (OR	AS A CONSEQ	UENCE OF	F);	157.1			-		
z		· ( ando	solve	P X	EALX	Fachers	2			!	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OH	AS A CONSEQ	UENCE OF	F):	1					
S	CAUSE (Disease or injury	RID HI	las IV	1901	1 100+	Leng					
Ĕ	that initiated events	DUE TO (QR	AS A CONSEQ	UENCE OF	F):	/					
표	resulting in death) LAST	unon	wa			1					
8	•									1	
甘	PART II. Other significant condition	s contributing to dea	th but not re	sulting i	in the underl	ying cause given in		AUTOPSY		ERE AUTOPSY FINDINGS	
DICAL							1 _ YES		c	MAILABLE PRIOR TO OMPLETION OF CAUSE	
								2 🗆 110	- 1	F DEATH?	
ME						<del></del>	_		'	YES 2 NO	
PHYSICIAN:	OF MAC CACE DEFENDED TO THE										
ō	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		T	OTHER:	PLACE OF DEATH (C	neck only one)				
S	1 TES 2 NO	1 Inpatient 2 ER/	Outpatient 3	□ DOA		iome 5 🗆 Residence	6 Other (Specify)				
둦	27. MANNER OF OEATH	26a. DATE OF INJU (Month, Day, Ye	PRY	26b, TIM	E OF 28c.	INJURY AT WORK?	28d. DESCRIBE HOW	INJURY OC	CURED		
BY	1 Natural 5 Pending	(Morkin, Day, 16	,	1145		YES 2 NO					
	2 D Suleide	28e. PLACE OF INJ	URY — At hor	ne, farm, s	street, factory, o	ffice	261. LOCATION (Street	and Numbe	r or Bural Bou	the Mumber	
	4 Homicide 6 Could not be	building, atc.	(Specify)		8201111 1912-1911		City or Town, State		· Or Flores Floor	no rumos,	
			_								
ių	20e CERTIFIER	Market .	nowledge, des	th occurre	ed at the time,	lete end place, and due	to the cause(e) and me	nner as sta	ted,		
APLE	29a, CERTIFIER (Check only	To the best of my k			- 1	double accounted at the	time data and place a				
OMPLE	(Check only	to the best of my less of examination the basis of examination	setion end/or ir	rvestigatio	nt, in my opinio	i, death occurred at the	time, date and place, a	nd due to ti	he cause(s) a	nd menner as atated.	
COMPLETED	(Check only	On the basis of examin	setion end/or in	ivestigatio	ni, in my opinio						
#	(Check only one) 2 MEDICAL EXAMINE	On the basis of examin	nation end/or in	rveztigatio	ni, in my opimo	29c. LICENSE NU	MBER /			roytin, Day, Year)	
	(Check only one) 2 MEDICAL EXAMINE 290. HIGHARTURE AND TITLE OF CERTIFIES	On) the basis of examin	nation end/or in				MBER /				
#	(Check only one) 2 MEDICAL EXAMINE	On) the basis of examin	nation end/or in			29c. LICENSE NU	MBER /				
#	(Check only one) 2 MEDICAL EXAMINE 200. INSUMATURE AND TITLE OF CERTIFIC 30, MAME AND ADDRESS OF PERSON WH	On) the basis of exemir	F DEATH (ITEM	27) (Type,	Print)	29c. LICENSE NU	MBER /				
#	(Check only one) 2 MEDICAL EXAMINE 290. HIGHARTURE AND TITLE OF CERTIFIES	On) the basis of examin	F DEATH (ITEM	27) (Type,	Print)	29c. LICENSE NU	MBER /				

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page the within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 Rev 1/89

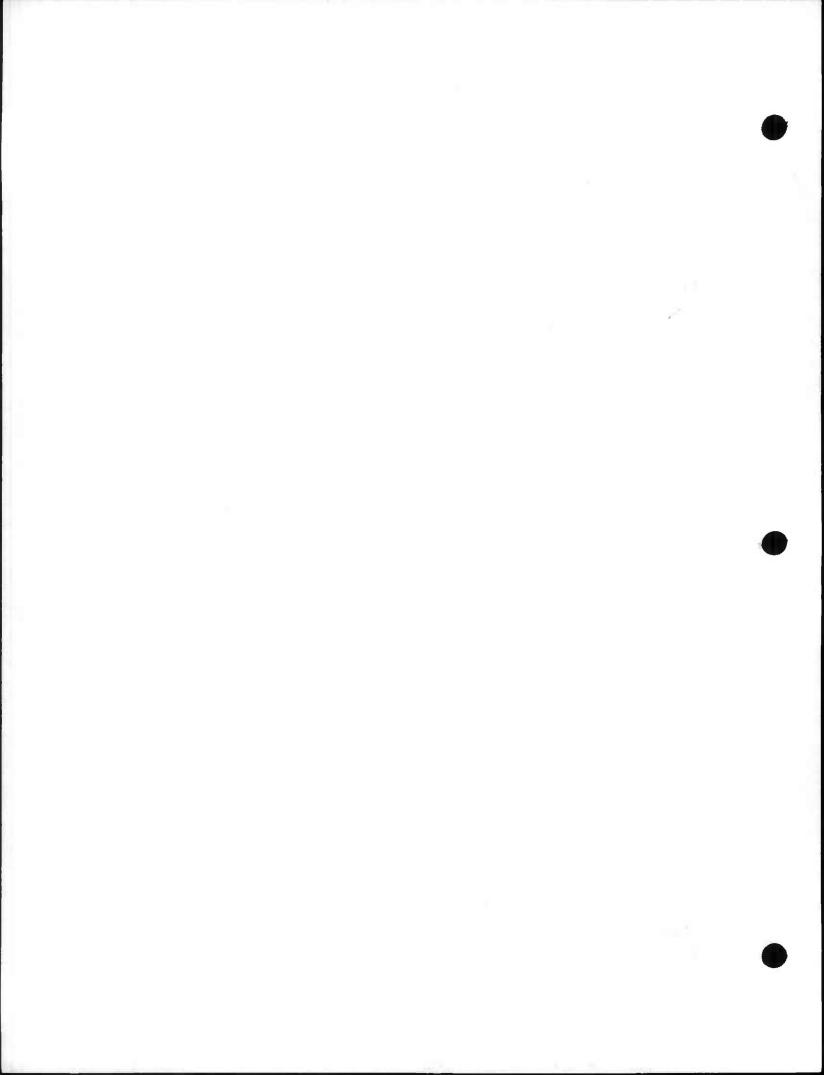


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	ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death
	ATTENDING

PHYSICIAN: The law requires that the death certificate be executed within 24 foturs after death. Pane 6 may be retained by the brockets or attending observing	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.	orior to burial, cremation, or removal.	traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

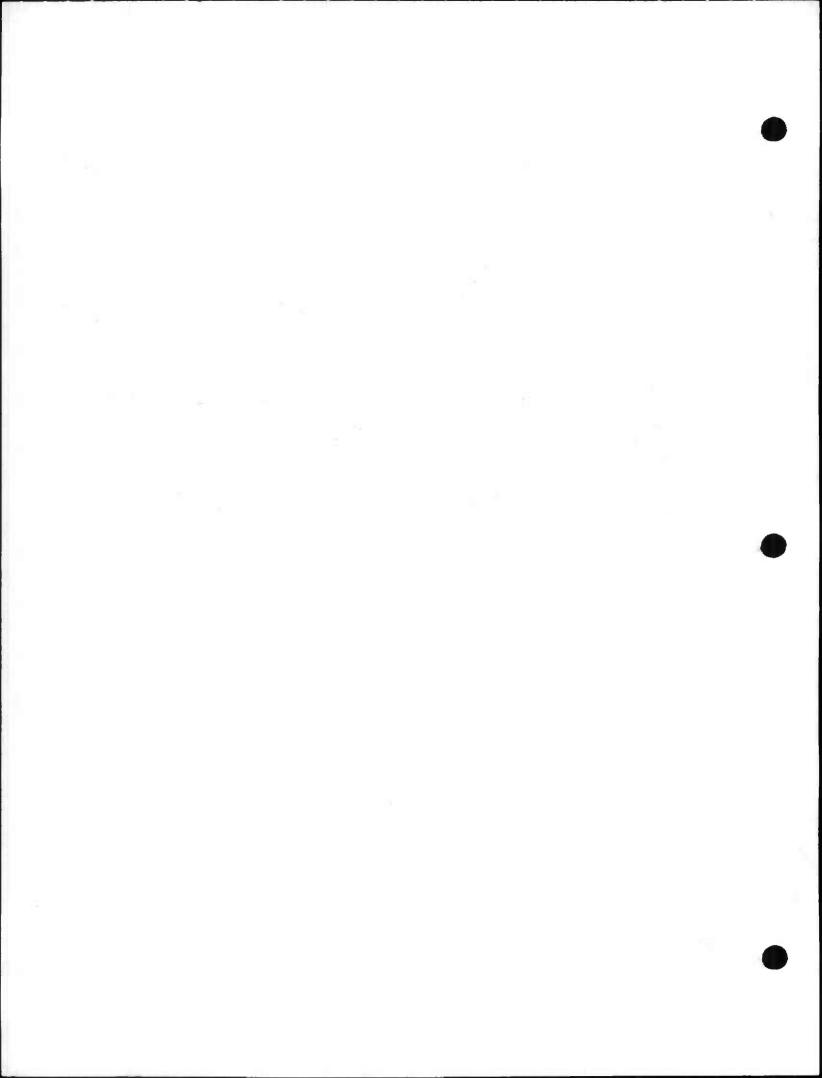
FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTII	FICATE OF	DEATH	REG. I	10.				
- 7	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH			3. TIME OF DEAT	н	
- 1	Ruth Shaml	berger	Wynn			монтн 3	L8	93	11:50	Рм	
			AGE (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	.0	_			
		1   M 2   F		MONTHS DAYS	HOURS MIN.	(Month, Day, Year,		Countr		reign	
	100-00-0740		81 YRS.			11/ 14/	11		ryland		
_ ]	Sa. FACILITY NAME (If not institution, give stre	set and number)		9b. CITY, TOWN	OR LOCATION OF DE	ATH		UNTY OF D			
DIRECTOR	SALISBURY NURSING	& REHAB C	ENTER	SALISB	JRY, MD.	21801	WIC	COMIC	0		
5	RESIDENCE OF DECEDENT										
2	10a. STATE 10b. COUNTY		10c. CI	TY, TOWN OR LOCA		LIMITS?					
		icomico		Salis	bury				1 K YES 2	но	
¥ I	10s. STREET AND NUMBER			10	f. ZIP CODE		10g. Cl	TIZEN OF W	WHAT COUNTRY?		
E	804 Spring Ave.				21801		U	SA			
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EV	ER IN U.S. ARMED	13. WAS DE	CENDENT OF HISPAN	IIC ORIGIN? (Specify	Ves or No	14 BACE	E — American India		
	1 Never Married 2 Married	FORCES? 1 1	YES 2 NO	If yes, s	pecify Cuban, Mexica	n, Puerto Rican, etc.)		Black	k, White, etc.		
B	3 Widowed 4 Divorced	IF YES, GIVE WAR C	OH DATES	1 L YE	S 2 🔀 NO Specify	r:		Spec/	hite		
ا بی	15. DECEDENT'S EDUCA	ATION	16a, DECEDENT	S USUAL OCCUPATI	ON	16b. KINO OF	HICINESS /IN		nite		
Ē I	(Specify only highest grade of Elementary/Secondary (0-12)		(Give kind of	work done during m	ost of working	THE RAISE OF	JOSHIL SS/III	DOSTAT			
ا ٦	12	College (1-4 or 5 +)	1							T I	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	4	house	wile							
		C11				ME (First, Middle, Maid					
W	Arthur Evert	Shamberge			Persi				_		
٩	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or					
	Janet Sample		Rt.	2, Box 2	07, Parso	onsburg,	Md. 2	1849			
	20e. METHOD OF DISPOSITION 1 ABuriat 2 Cremetion 3 Remov	vel from State	20b. PLACE AND DATE		ame of	DATE 20c.	LOCATION -	- City or To	wn, State		
	4 Donation 5 Other (Specify)		Wicomico	otner piece) Memori:	1 Park	3/22	Solio	h	Ma		
- 1	21. SIGNATURE OF FUNDIAL SERVICE LICE	HSEE!		22. NAME A	ND ADDRESS OF FA	CILITY		шигу	, 14/7		
- 1	· latin !	100/10	all			eral Home					
	110111	recjou	sug	501	snow Hil	1 Rd., Sa	lisbu	ry, l	Md. 2180	1	
	23. RAPT I. Enter the diseases, Dr CD shock, or heart feliure. Li	implications that cause (	used the death. Do	not anter the me	ode of dying, suci	h as cardiac or re	piratory a	rrest,	Approxima		
	IMMEDIATE CAUSE (Finel								Interval Be Onset and		
	disease Dr condition resulting in death)	MoTT	257477	C ADO	un CA o	FALLO	O. AN	Tub	0	10.700-	
	testing in ceating	DUE TO (OR	7-STATTI	OF):							
	1								i		
z I	The state of the s										
NO	Sequentially list conditions, if any leading to immediate	DUE TO (OR	AS A CONSEQUENCE	DF):					<u> </u>		
ALION	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR	AS A CONSEQUENCE	OF):							
FICATION	if any, leading to immediate		AS A CONSEQUENCE (					<u>.</u>			
RTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury										
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR	AS A CONSEQUENCE (	OF):							
5	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR	AS A CONSEQUENCE (	OF):	g cause given in	Part I. 24a. WAS	AN AUTOPSY	24b.	WERE AUTOPSY FII		
ICAL CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR contributing to dear	AS A CONSEQUENCE (	OF):	g cause given in	PERF	ORMED?	24b.	COMPLETION OF C	ro	
EDICAL CE	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	Contributing to dea	AS A CONSEQUENCE (	OF):	g cause given in	PERF		24b.	AMAILABLE PRIOR 1 COMPLETION OF CO OF DEATH?	NO AUSE	
MEDICAL CE	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR contributing to dear	AS A CONSEQUENCE (	OF):	g cause given in	PERF	ORMED?	24b.	COMPLETION OF C	NO AUSE	
MEDICAL CE	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	Contributing to dea	AS A CONSEQUENCE (	In the underlyin		PERF	ORMED?	24b.	AMAILABLE PRIOR 1 COMPLETION OF CO OF DEATH?	NO AUSE	
MEDICAL CE	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions	contributing to dea	AS A CONSEQUENCE (	In the underlyin	LACE OF DEATH (Ch	PERF 1 VES	ORMED?	24b.	AMAILABLE PRIOR 1 COMPLETION OF CO OF DEATH?	NO AUSE	
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SICIAN: MEDICAL CE	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions  PART II.	contributing to dea	AS A CONSEQUENCE ( th but not resulting  AS A CONSEQUENCE ( TOUTPASSED 1	In the underlyin  28. P  OTHER: 4 M Nursing Hor	LACE OF DEATH (Ch	PERF 1 VES	ORMED? 2 NO		AMAILABLE PRIOR 1 COMPLETION OF CO OF DEATH?	NO AUSE	
Y PHYSICIAN: MEDICAL CE	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions	Contributing to dea	th but not resulting	28. P OTHER: 4 Nursing Hor ME OF UNITY W M 1	LACE OF DEATH (Chr. ne 5   Rasidence JURY AT JRK7 YES 2   NO	PERF 1 YES  ack only one)  8 Other (Specify)	ORMED? 2 NO		AMAILABLE PRIOR 1 COMPLETION OF CO OF DEATH?	NO AUSE	
BY PHYSICIAN: MEDICAL CE	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions  PART II.	Contributing to dea	AS A CONSEQUENCE ( th but not resulting  AS A CONSEQUENCE ( th but not resulti	28. P OTHER: 4 Nursing Hor ME OF UNITY W M 1	LACE OF DEATH (Chr. ne 5   Rasidence JURY AT JRK7 YES 2   NO	PERF 1 YES  Dick only one)  8 Other (Specify)  28d. DESCRIBE HOT  28t. LOCATION (Street	ORMED? 2 NO V INJURY OC	CCURED	AMALABLE PRIOR COMPLETION OF CO	NO AUSE	
BY PHYSICIAN: MEDICAL CE	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions  PART II.	CONTRIBUTION TO CONTRIBUTE TO	AS A CONSEQUENCE ( th but not resulting  AS A CONSEQUENCE ( th but not resulti	28. P OTHER: 4 Nursing Hor ME OF UNITY W M 1	LACE OF DEATH (Chr. ne 5   Rasidence JURY AT JRK7 YES 2   NO	PERF 1 YES  1 Other (Specify)  28d. DESCRIBE HOT	ORMED? 2 NO V INJURY OC	CCURED	AMALABLE PRIOR COMPLETION OF CO	NO AUSE	
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BY PHYSICIAN: MEDICAL CE	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  25. WAS CASE REFERRED TO MEDICAL  EXAMINER?  1	Contributing to dear  CONS DISC  WRS CD  WRS C	AS A CONSEQUENCE ( th but not resulting  AS CONSEQUENCE ( TOUTpatient 3 DOA  JURY 28b. Till  JURY At home, farm,  (Specify)  (nowledga, death occur	28. P OTHER: 4 Nursing Hor ME OF USEN MUTUAL Street, factory, office	LACE OF DEATH (Chr. ne 5   Rasidence JURY AT JRK7 YES 2   NO	PERF 1 YES  1 YES  3 Other (Specify)  28d. DESCRIBE HOT  City or fown, Ste  to the cause(a) and re	ORMED? 2 NO V INJURY OC st and Number	COURED or Or Rural R	AMALABLE PRIOR COMPLETION OF C	ro AUSE /O	
BY PHYSICIAN: MEDICAL CE	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions  PART II.	Contributing to dear  CONS DISC  WRS CD  WRS C	AS A CONSEQUENCE ( th but not resulting  AS CONSEQUENCE ( TOUTpatient 3 DOA  JURY 28b. Till  JURY At home, farm,  (Specify)  (nowledga, death occur	28. P OTHER: 4 Nursing Hor ME OF USEN MUTUAL Street, factory, office	LACE OF DEATH (Chr. ne 5   Rasidence JURY AT JRK7 YES 2   NO	PERF 1 YES  1 YES  3 Other (Specify)  28d. DESCRIBE HOT  City or fown, Ste  to the cause(a) and re	ORMED? 2 NO V INJURY OC st and Number	COURED or Or Rural R	AMALABLE PRIOR COMPLETION OF C	ro AUSE /O	
COMPLETED BY PHYSICIAN: MEDICAL CE	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  25. WAS CASE REFERRED TO MEDICAL  EXAMINER?  1	Contributing to dear  CONS DISC  WRS CD  WRS C	AS A CONSEQUENCE ( th but not resulting  AS CONSEQUENCE ( TOUTpatient 3 DOA  JURY 28b. Till  JURY At home, farm,  (Specify)  (nowledga, death occur	28. P OTHER: 4 Nursing Hor ME OF USEN MUTUAL Street, factory, office	LACE OF DEATH (Che ne 5	PERF 1 YES  1 YES  Other (Specify) 28d. DESCRIBE HOT  28t. LOCATION (Streetly or Town, Stet) to the cause(s) and ritime, deta and place,	ORMED? 2 NO V INJURY OF	COURED or or Rural R	AMALABLE PRIOR COMPLETION OF C	ro AUSE /O	
BE COMPLETED BY PHYSICIAN: MEDICAL CE	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions  C. Cause of the conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  C. Cause of the conditions  PART II. Other significant conditions  C. Cause of the conditions  PART II. Other significant conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cau	DUE TO (OR  Contributing to dea  ONS DISC  WRS CD	AS A CONSEQUENCE of the but not resulting the second of the but not resulting the second of the seco	28. P OTHER: 4 Nursing Hor ME OF 28c. N. JURY M 1  street, factory, office red at the time, date	LACE OF DEATH (Che ne 5	PERF 1 YES  1 YES  Dock only one)  8 Other (Specify)  28d. DESCRIBE HOT  City or Town, Ste  to the cause(a) and ri	ORMED? 2 NO V INJURY OF	COURED or or Rural R	AMALABLE PRIOR COMPLETION OF C	ro AUSE /O	
BE COMPLETED BY PHYSICIAN: MEDICAL CE	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions  PART II.	DUE TO (OR  Contributing to dea  ONS DISC  WRS CD	AS A CONSEQUENCE of the but not resulting the second of the but not resulting the second of the seco	28. P OTHER: 4 Nursing Hor ME OF 28c. N. JURY M 1  street, factory, office red at the time, date	LACE OF DEATH (Che ne 5	PERF 1 YES  1 YES  Other (Specify) 28d. DESCRIBE HOT  28t. LOCATION (Streetly or Town, Stet) to the cause(s) and ritime, deta and place,	ORMED? 2 NO V INJURY OF	COURED or or Rural R	AMALABLE PRIOR COMPLETION OF C	ro AUSE /O	
Y PHYSICIAN: MEDICAL CE	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions  C. Call II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  C. Call II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PAR	DUE TO (OR  Contributing to dea  ONS DISC  WRS CD	th but not resulting  AS A CONSEQUENCE of the but not resulting the Second of the Seco	26. P OTHER: 4 Manualing Hor ME OF Street, factory, office red at the time, date ton, in my opinion, of	LACE OF DEATH (Cheme 5   Residence JURY AT PKS 2   NO re	PERF 1 YES  1 YES  26t. LOCATION (Streetly)	V INJURY OC None st and Number let of the stand due to the stand of th	occured ar or Rural Rura	AMALABLE PRIOR COMPLETION OF C	ro AUSE /O	
BE COMPLETED BY PHYSICIAN: MEDICAL CE	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions  C. Call II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  C. Call II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PAR	DUE TO (OR  CONTributing to dea  ONS DISC  WRE CO  HOSPITAL:    Inpetient 2   ERV    28a. DATE OF INJU   (Month, Day, Ye   28a. PLACE OF INJ   building, etc. ()  IAN: To the best of my k   On the besis of axamir  COMPLETED CAUSE OF	AS A CONSEQUENCE ( th but not resulting  AS A CONSEQUENCE ( th but not resulting  AS A CONSEQUENCE ( the but not resulting  COUTPATH ( TO A HOME, farm, (Specify)  TO A HEAT, TESIGNATURE	26. P OTHER: 4 Manualing Hor ME OF Street, factory, office red at the time, date ton, in my opinion, of	LACE OF DEATH (Cheme 5   Residence JURY AT PKS 2   NO re	PERF 1 YES  1 YES  Other (Specify) 28d. DESCRIBE HOT  28t. LOCATION (Streetly or Town, Stet) to the cause(s) and ritime, deta and place,	ORMED? 2 NO V INJURY OF	occured ar or Rural Rura	AMALABLE PRIOR COMPLETION OF C	ro AUSE /O	
BE COMPLETED BY PHYSICIAN: MEDICAL CE	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions  C. Cause of the conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  PART II. Other significant conditions  C. Cause of the conditions  PART II. Other significant conditions  C. Cause of the conditions  PART II. Other significant conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cause of the conditions  C. Cau	DUE TO (OR  CONTributing to dea  ONS DISC  WRE CO  HOSPITAL:    Inpetient 2   ERV    28a. DATE OF INJU   (Month, Day, Ye   28a. PLACE OF INJ   building, etc. ()  IAN: To the best of my k   On the besis of axamir  COMPLETED CAUSE OF	th but not resulting  AS A CONSEQUENCE (  the but not resulting  AS A CONSEQUENCE (  the but not resulting  AS A CONSEQUENCE (  the but not resulting  Courtpatient 3 DOA  DOA  REY  28b. Till  RESULT (  Specify)  The but not resulting  Courtpatient 3 DOA  REY  28b. Till  RESULT (  RESULT (  TOA HEAT. TE	26. P OTHER: 4 Manualing Hor ME OF Street, factory, office red at the time, date ton, in my opinion, of	LACE OF DEATH (Cheme 5   Residence JURY AT PKS 2   NO re	PERF 1 YES  1 YES  26t. LOCATION (Streetly)	V INJURY OC None st and Number let of the stand due to the stand of th	occured ar or Rural Rura	AMALABLE PRIOR COMPLETION OF C	ro AUSE /O	



BALTIMORE, MARYLAND 21215-0020	in 24 hours after death. Page 6 may be retained by the hospital or attending physi	sly filled in by the funeral director, page 5 should be detached for use as the buria ation, or removal.	, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physicia	TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-to be filed within 72 hours after death with the State Deor, of Realth and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND / CE	DEPARTMENT OF HEALT	H AND MENT	AL HYGIENE REG. NO.		, 03007
	1. DECEDENT'S NAME (First, Middle, Last)	West		2. DAT	TE OF DEATH	7 9	3. TIME OF DEATH
	221-07-0186	5. SEX 6. AGE (In yrs. lest	VRS. FUNDER 1 YEAR IF UND VRS. MONTHS DAYS HOURS	DER 24 HRS. 7. DAT	E OF BIRTH nth, Day, Year)		BIRTHPLACE (State or Foreign Country)
TOR	90. FACILITY NAME (If not institution, give stre  VA Medical  RESIDENCE OF DECEDENT	Center	96. CITY, TOWN OR LOCAL	MORE		Bal	OF DEATH
DIREC	10e. STATE 10b. COUNTY	ltimore	10c. CITY, TOWN OR HOGATION	RFL			10d. INSIDE CITY LIMITS2  1 TES 2 NO
FUNERAL DIRECTOR	10e. STREET AND NUMBER	1 1	10f. ZIP CC			10g. CITIZEN	OF WHAT COUNTRY?
BY FUN		12. WAS DECEDENT EVER IN U.S. ARM FORCES? 1 TES 2 N IF YES, GIVE WAR OR DATES		ben, Maxicani, Puerte			RACE — American Indian, Black, White, etc. Specify:
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)		CEDENT'S USUAL OCCUPATION  Se blad of work done during most of work  Do Not use entired.)	Aing 16	Sb. KIND OF BUSI	NESS/INDUST	RY \
OMPL	17. FATHER'S NAME (First, Middle, Last)	7	ETILED 16. MC	OTHERIS NAME (First	Aut.	urneme)	Machi
B	THE UTS Y	WEST	. MAILING ADDRESS (Street and Num	Sold S	BLAKE	States Zin Cox	EST-
10	EditK (WEST	20h PLACEA	NO Edge We	6d 54	TE 20c. LOC	Hin	12CR 2/229 or Topun, State
	1 Dental 2 Commission 3 Remove  T Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LICEN	of from State ceoeglay, con	natory or other place)  SING  22. NAME AND ADDI	ABK 3/2		TARPI	town mo
1	Dusell	Josh	Salisbo	eky !	Ma 15	FOR	17/5
	IMMEDIATE CAUSE (Finel	st only one ceuee on eech line.			rdlec or reepira	atory erreet.	Approximete Interval Between Onset and Death
	disease or condition resulting in death)	DUE TO (OR AS A CONSECU	e Cancer				>2yrs
ATION	Sequentielly list conditions, if any, leading to immediate	DUE TO (OR AS A CONSEO	UENCE OF):				
CERTIFICATION	ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	DUE TO (OR AS A CONSEO	UENCE OF):				
AL CEF	PART II. Other significent conditions	contributing to deeth but not re	sulting in the underlying ceuse	given in Part I.	24s. WAS AN A	UTOPSY	24b. WERE AUTOPSY FINDINGS
EDICA					PERFORM 1 YES 2		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL		24 81 407 05	DESTRUCTION AND ADDRESS OF THE PROPERTY OF THE			1 YES 2 NO
YSIC	EXAMINER?  1 YES 2 NO	IOSPITAL:    Inpatient 2   ER/Outpatient 3	OTHER:	DEATH (Check only of Reeldence 8  Oth			
ВУ РН	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY AT WORK?  M 1 YES 2		EŞCRIBE HOW INJ	JURY OCCURE	ED
	3 Suicide 8 Could not be 4 Homicide determined	26e. PLACE OF INJURY — At hombuilding, etc. (Specify)	ne, ferm, street, factory, office		CATION (Street end y or Town, State)	d Number or R	ural Route Number,
COMPLETED		AN: To the bast of my knowledge, dead On the basis of examination end/or in					use(e) end manner ee stated,
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	er more	29c. LI	CENSE NUMBER		29d. DATE SIG	NED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO C	eene St	Balt M	D 2	10.61		110770
10	31. DATE FILED (Month, Day, Year) MAR 2. 2. 1993	22. REGISTRAR'S SIGNATURE fulia Davidson-Rando	ell		-	-	



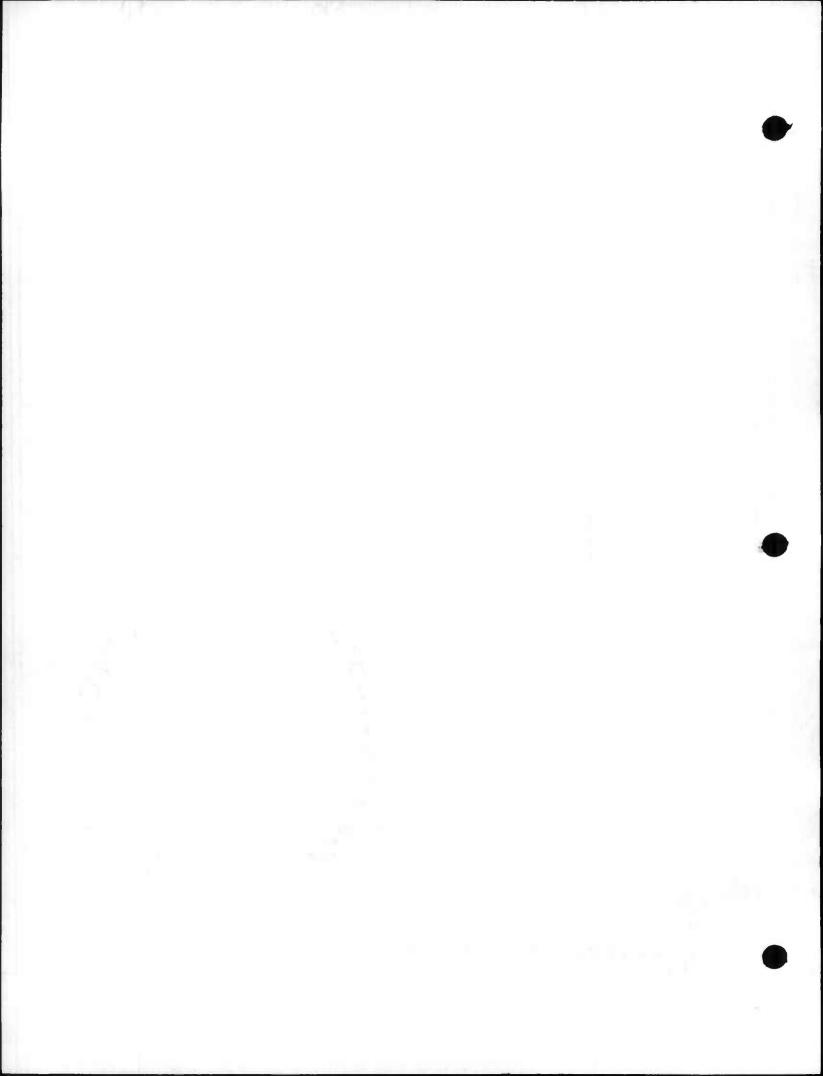
1	STATE REGISTRAR		STATE OF N		/ DEPAR					WENTA	REG. NO			
	1. DECEDENT'S NAME (First, M	liddle, Last)				-		DEA		2. DATI	E OF DEATH			3. TIME OF DEATH
	Ruth			L.		1.	Lilia	0		MONT	th c	MY LI GC	YEAR	0770
	4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs.	lest birthday)	IF UNDE	R 1 YEAR	IF UNDER	24 HRS.		OF BIRTH	7//77		PLACE (State or Foreign
	544-16-3682		1 🗆 M 2 😡 F	88	YRS.	MONTHS	DAYS	HOURS	MIN.	(Mon	th, Day, Year) 23,	1005	Country	iana
	9e. FACILITY NAME (If not instit	tution, give s	treet and number)	- 00		9b. CIT	Y. TOWN C	R LOCATION	ON OF DE		. 23,		NTY OF D	
5	PENINSULA RI	FCION	AI MEDIC	AI CENT	משי									
DINECTOR	RESIDENCE OF DECE		AL MEDIC	AL CENT	EK	0	WLTP	BURY				IWI	COMI	00
Ĺ	10a. STATE 1	06. COUNTY	1		10c. CIT	Y, TOWN	TOWN OR LOCATION							10d. INSIDE CITY
5	Maryland	Wicom	ico			Sali	isbui	y					- 1	LIMITS?
	10a. STREET AND NUMBER							ZIP CODE	E			10g. CIT	IZEN OF W	HAT COUNTRY?
	Rt. #6 Box 1	46					2	1801				II	S.	Δ
LONEDAL	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S.	ARMED	13.	WAS DEC	ENDENT C	F HISPAN	IC ORIGI	IN? (Specify Ye		14. RACE	- American Indian.
	1 Never Married 2 Ma		FORCES? 1 IF YES, GIVE W	YES 2 5	₫NO		If yes, sp	2 NO	n, Mexica	n, Puerto	Rican, etc.)		Specif	White, etc.
5	3 Widowed 4 Divorce	d						Z QQ IIIO	ороспу			- 1	эресл	white
3	15. DECED (Specify only h	ENT'S EDU	CATION		DECEDENTS					16	b. KIND OF BU	SINESS/INC	DUSTRY	
i	Elementary/Secondary (0-12		College (1-4 or 5		(Give kind of life. Do NOT u	work done se retired.)	aunng mo	ST OF WORTER	g					
	12			Но	omemak	er				07	wn hom	e		
COMPLETED	17. FATHER'S NAME (First, Midd	fle, Last)						18. MOTI	HER'S NAI		Middle, Maiden			
	Jesse Colcle	sser						Ann	a Na	010	Colcl	accar		
5	19a. INFORMANT'S NAME (Type			-	19b. MAJLING	AODRES	S (Street a				nber, City or Tox			
2	Betty W. Ell:	า๋ร									, Md 2			
ı	20a. METHOD OF DISPOSITION			20h PLAC	EANDDATE				TIPD			CATION -	City or Toy	un State
	1 ☐ Burial 2 🙀 Cremation 4 ☐ Donation 5 ☐ Other (S)		oval from State	cemetery, c	crematory or o	ther place	1		4	1	15 Geo		-	
	21. SIGNATURE OF FUNERAL S		ENSEE A	n jeaste	EIII DI			ID ADDRES			13 [Geo	rgeto	WII,	DE_
Ŷ.	1/1	, 111	1 ///	41				Fune			e			
	23. PART I. Enter the dise	W	1 Ako	46		P.	0.	Box	204	De:	lmar.	DE 19	940	
	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list condition fany, leading to immedia cause. Enter UNDERLYING	ns, ite	a. DUE TO OUE TO		EQUENCE O		He	er.	+ 1	Cac	ilup			Interval Betweer Onset and Deatl
	CAUSE (Disease or Injury that initiated events resulting in death) LAST	1	d	(OR AS A CONS									4	
	PART II. Other significant	condition	s contributing to	death but no	t reaulting	In the u	nderlying	) cause (	given in	Part I.	24a. WAS AMPERFO	RMED?	24b.	WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
	25. WAS CASE REFERRED TO B EXAMINER?	MEDICAL	HOSPITAL:			0.7		ACE OF D	EATH (Chi	ick only o	nne)			
	1 TYES 2 PHO		1 Inpatient 2	ER/Outpatient	3 DOA	OTHE 4 Nu		5 □ Re	sidence	6 🗆 Oth	er (Specify)			
	27. MANNER OF OEATH		28a. DATE OF (Month, D		26b. TIN	E OF JURY	28c. INJ WO	URY AT	-	28d. DE	SCRIBE HOW	INJURY OC	CURED	
1		naing estigation				M	1 🗆 1	'E\$ 2 [	NO					
	3 Suicide 5 Co	uld not be termined	28e. PLACE O building,	F INJURY — At etc. (Specify)	home, farm,	street, fac	tory, office				CATION (Street or Town, State		or Rural R	oute Number,
			CIAN: To the best of R: On the basis of a											and manner as stated.
	296. SIGNATURE AND TITLE OF	F CERTIFIER	0	1 6				29c. LICE	NSE NUM	BER		29d. DAT	E SIGNED	(Month, Day, Year)
	1 mouns	1 -	U	9				03	113	Y 6	>		3/19	1/95
	30. NAME AND ADDRESS OF P	ERSON WH	COMPLETED CAU	SE OF DEATH (IT	TEM 27) (Type		106	m	il	N	st:	suite	1	53,21801
	31. DATE FILED (Month, Day, Yea MAR 15 19	93	32. REGISTRA	A'S SIGNATURE	Lees-									

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 Rev 1/89



1 - STATE REGISTRAR	STATE OF I			TMENT OF			MENTAL HYGIE! REG. NO			
1. DECEDENT'S NAME (First, Middle, Last)					BEA		2. DATE OF DEATH	,.		3. TIME OF DEATH
ANNIE	M		WT	ILSON			MONTH (	LS	YEAR 93	0030 M
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last bir		IF UNDER 1 YEAR	IF UNDE	R 24 HRS.	7. DATE OF BIRTH			PLACE (State or Foreign
214-23-5777	1 🗆 M 2 💢 F	53	YRS.	MONTHE DAYS	HOURS	MIN.	(Month, Day, Year) 06-02-3	.	Country	)
9a. FACILITY NAME (If not institution, give st	reet and number)			9b. CITY, TOWN	OR LOCAT	ION OF DE		7	NTY OF DE	ATU
418 CARTWRIGHT DE	are ere.					1011 01 01	-0111			
RESIDENCE OF DECEDENT	CIAE			FRUIT	LAMD			WIC	COMIC	0
10a. STATE, 10b. COUNTY	ICOMI	CO 10	Oc. CITY	ALISB	IRY	/				10d. INSIDE CITY LIMITS? 1 YES 2 1 NO
100. STREET AND NUMBER	It Aver	III Fru	Hla	IM!	2/ 8	36		10g. CITI		HAT COUNTRY?
11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AFMED	)	13. WAS DE	CENDENT	OF HISPAN	IIC ORIGIN? (Specify Ye	s or No—	14. RACE	— American Indian,
1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 IF YES, GIVE W	YES 2 NO			S 2 NO		n, Puerto Rican, etc.)		Black, Specify	White, etc.
15. DECEDENT'S EDUC (Specify only highest grade	ATION completed)	16e. DECED	ENT'S L	USUAL OCCUPAT	ION		16b. KIND OF BU	SINESS/IND	USTRY	22:10:1
Elementary/Secondary (0-12)	College (1-4 or 5		NOT use	PA	ost or work	ng	Nai	56	2	
17. FATHER'S NAME (First, Middle, Last)	/				1a. MOT	HER'S NA	ME (First, Middle, Maiden	Surpeme)		
George Wright					1	rex	e Wrigi	1+		
190 INFORMANTS NAME (Typo/print)	son	19b. M/	AILING	ADDRESS (Street	and Numbe	gr Aural I	Houte Number, City of Tow	vn, State, Zip	Cope)	1801
20a. METHOD OF DISPOSITION  t	vat from State	20b. PLACE AND cometery, cremato		ner place	lame of	To.,	DATE 20c. LC	CATION -	City or Tow	rn, State
21. SIGNATURE OF FUNERAL SERVICE LICE	ENSES	- Mada	7000	22. NAME /	ND ADDRE	BS,OF FA	CILITY AL	- an	(has	12/801
Russel G.	tooks	_	4	20.0	V. I Box	\$ also	Ma Salus	drung.	Md	31801
23. PART I. Enter the diseases, or conshock, or heart failure. L	omplications the	csused the death.	. Do no	ot enter the m	ode of dy	ing, suci	h as cardlec or resp	Iratory err	est,	Approximate
IMMEDIATE CAUSE (Finei disease or condition resulting in death)	ARTERI	OSCLEROTI			SCUL	AR D	ISEASE			Onset and Death
	DUE TO	(OR AS A CONSEQUEN	NCE OF)	):						
Sequentielly list conditions, if sny, leading to immediate	DUE TO	OR AS A CONSEQUEN	NCE OF)	):						
CAUSE (Disease or Injury										
that initiated events resulting in death) LAST	DUE TO	OR AS A CONSEQUEN	NCE OF)	):						
d d										
PART II. Other significant conditions	contributing to	death but not reau	Iting In	the underlying	Q cause i	given in	Part i, 24a, WAS AN	VPROTILIA	24b 1	WERE AUTOPSY FINDINGS
RHEUMATOID ARTHR				· · · · · · · · · · · · · · · · · · ·	9 00000	givon in	PERFO	RMED?		AVAILABLE PRIOR TO
EXOGENOUS OBESIT							1 YES :	NO		OF OEATH?
							_			t 🗌 YES 2 🗍 NO
25. WAS CASE REFERRED TO MEDICAL				20.0						
EVALUATION	HOSPITAL:	ER/Outpatient 3 🗆 🗅		OTHER:	1/		ick only one)			
27. MANNER OF DEATH	28a. DATE OF		b. TIME	4 Nursing Ho	JURY AT	esidence	8 Other (Specify) 28d. OESCRIBE HOW	N HIEN OCC	TUREO	
1 Netural 5 Pending	(Month, Da		INJU	IRY W	YES 2	NO.	200. OESCHIBE HOW	MJOHY OCC	UNEU	
2 Accident Investigation 3 Suicide & Could not be	28e. PLACE O	INJURY — At home, I	tarm, at			_ no	281. LOCATION (Street	and Number	or Pumi Do	ode Alexandra
4 Homicide datermined	building,	etc. (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Town, State)	)	or norm no	une Muniber,
29a. CERTIFIER (Check only t CERTIFYING PHYSIC	IAN: To the best of	my knowledge, death o	occurred	I at the time, dat	and place	, and dua	to the cause(a) and ma	nner aa state	ed.	
							time, data and place, ar			and manner as stated.
200. SIGNATURE AND TITLE OF CERTIFIER						ENSE NUM				Month, Day, Year)
July 6533.1	12.0.	DEP	UTY	, ME		D035			03-1	
36. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	E OF DEATH-(ITEM 27)							JJ 4.	
JOHN T. BULKELEY,				F ROAD,	SAL	ISBU	RY, MARYLA	ND,21	.801	
MAR 1 8 1993	Julia David	SON-Randell								

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the lower signed by the attending physician and completely filled in by the luneral director, page 5 should be detached for use as the burial-transit permit. Page be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

		1. DECEDENT'S NAME (First, Middle, Lest)		PP				2. DATE OF DEATH MONTH	DAY	993	3. TIME OF DEATH	
P		4. SOCIAL SECURITY NUMBER 214-46-5600	1 M 2 □ F	(In yrs less	YRS. MONT		HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) SEP 1	,1946	8. BIRTH	PLACE (State or Foreign	
	TOR	90. FACILITY NAME (If not institution, give so Washington Count RESIDENCE OF DECEDENT			96. 0	A	OR LOCATION OF DE	1		ASH		
77	DIRECTOR	West Virginia Berke			10c. CITY, TOV		ation aters				10d. INSIDE CITY LIMITS?	
E.		100. STREET AND NUMBER	; I G y		1911		Of, ZIP CODE		10a CI	IZEN OF V	1 YES 2 X NO	
n. ansit p	UNERAL	883 Perry Drive					25419			US.		
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit permotifiled at once.	ВУ Е	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR I	3 2 KN	MED IO	If yes, s	specify Cuban, Maxica	OF HISPANIC ORIGIN? (Specify Yes or No— en, Maxicen, Puerio Ricen, etc.)  Specify:  14. RACE — American Indian, Black, White, etc.  Specify:				
21215 at or attent for use as	8	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DE0	CEDENT'S USUA	L OCCUPAT	TION most of working	16b. KIND OF E	BUSINESS/IN	DUSTRY		
LAND 21: the hospital or detached for u	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille.	oo NOT use retir	ed.)	NOSE OF WORKING	C	onstr	uctio	n	
LAN the hor e detach t once.		17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	ME (First, Middle, Maid	en Surname)			
MARYLAND retained by the hospit 5 should be detached notified at once.	B	Clarence  19a. INFORMANT'S NAME (Type/Print)	Wesley		nipp	F00 (0)	Nona  and Number or Flural F	Mar:			Moats	
	2	Tina M.Poole			502-K	Lynne	ehaven Dr.	Hagers	town,N	1D 21		
MOR ge 6 ma lirector, p		1 🖾 Buriel 2 🗆 Cremation 3 🗆 Rem 4 🗆 Donation 6 🗆 Other (Specify)	oval from State	ob. PLACE A emetery, crer reenla	nd DATE OF DIS natory or other pla WN MEMOL	ial Pa	irk March 2	2,1993 Wi	LOCATION — lliams	City or Tor	wn, Stata ,MD 21795	
BALTIMORE, after death. Page 6 may be by the funeral director, page moval.		21. BIGNATURE OF PUMERAL SERVICE LIK	Clan			22. NAME	AND ADDRESS OF FAC RNE FUNERA BOX # 348	CILITY				
760, ed within 24 hours at ompletely filled in by it, cremation, or remeevent, the medica	7	IMMEDIATE CAUSE (Final	e. BRAINSTE DUE TO (OR AS	.74 A CONSEC	Comp Proudence OF):	LETS 10	ode of dying, auch	n as cardiac or res	spiratory ar	reat,	Approximate interval Between Onset and Death	
P.O. BOX th certificate be ending physician if Hygiene prior to or other traus	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	DUE TO (OR AS  OUE TO (OR AS  d.	A CONSEO	UENCE OF):						2010	
ORDS, F that the death led by the atte th and Mental any Injury, o		PART ii. Other algnificent condition	a contributing to death	but not re	suiting in the	underlyi	ng ceuse given in i		AN AUTOPSY ORMED?	24b.	WERE AUTOPSY FINDINGS	
Sign Sign Sign Sign Sign Sign Sign Sign	MEDICAL							1 YES	4		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
W 5 8 0 2	- 11						<u></u>				· la res 2 pmo	
OF VITAL I PHYSICIAN: The law this certificate has b with the State Dept. Ked, or Item 23:	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO	HOSPITAL: 1 Ninpetient 2 ER/Out	tpatient 3		IER:	PLACE OF DEATH (Che					
ON OF V ING PHYSICIA with the marked, or	ву рну	27. MANNER OF OEATH  1 Netural 5 Pending 2 Accident Investigation	28a. OATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY	28c. IN	JURY AT ORK? YES 2 NO	28d. OESCRIBE HOY	V INJURY OC	CURED		
ISIC TTEND TOR: A after d		3 Suicide 6 Could not be determined	28e, PLACE OF INJUR' building, etc. (Spe	Y — At hon	ne, ferm, street,	fectory, offi	ca	261. LOCATION (Stree City or Town, Ste	et and Numbe te)	r or Rurel A	oute Number,	
로 작은 =	COMPLETE		CIAN: To the best of my know								and manner se atated.	
TO THE HOSPI TO THE FUNER be filed within	BE	296. SIGNATURE AND TITLE OF CENTIFIE	sentha	1			29c LICENSE NUM	BER (o(o	29d. DAT	E SIGNEO	(Month, Day, Year)	
	٥	30. NAME AND ADDRESS OF PERSON WH		EATH (ITEM	Λ	EL	LAG-ERSTO		) )/	740	,	
		31. DATE FILED (MOMAR 169 9 19	93 32. REGISTANNIS SIGN	NATURE	-Russel					110		

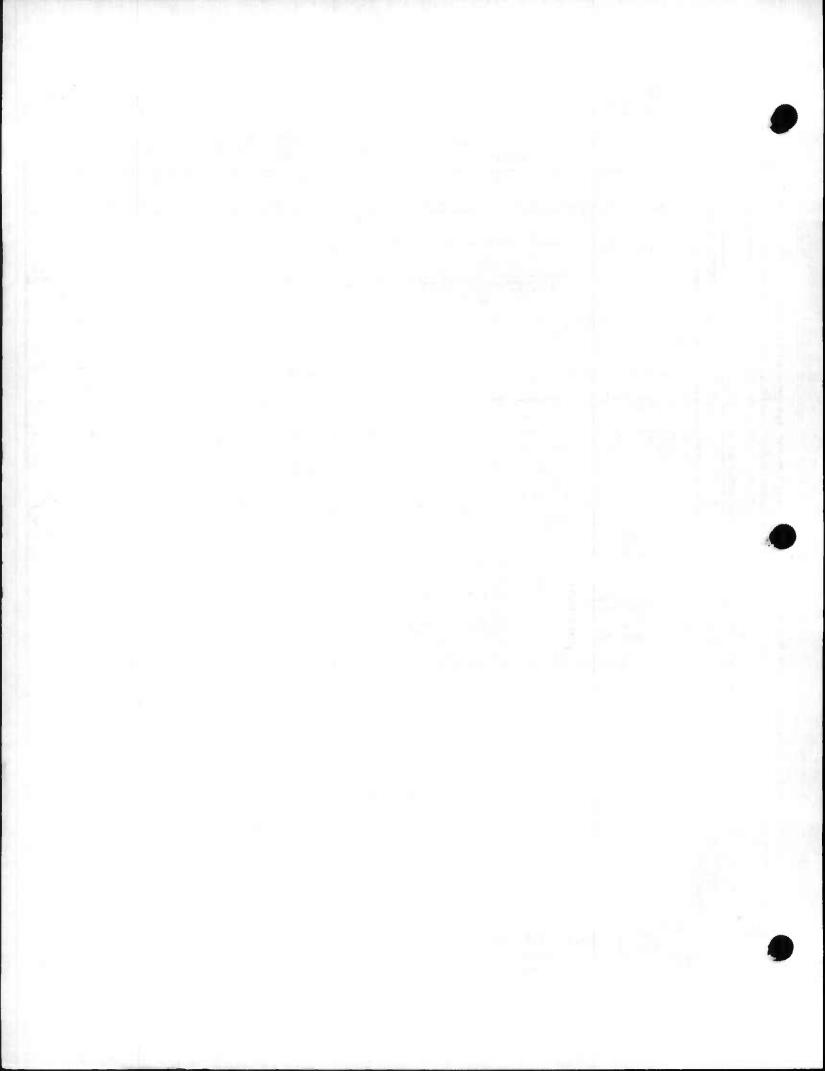
五 五 五 5	# # P W W W W W W W W W W W W W W W W W	UNE	RAL 72 I	DIRE Hours	and and burn	compl al, cr	ithin letely emati	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as it be filled within 72 hours after death with the State Debt, of Health and Mental Hygiene prior to burlal, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at ones.
HOSPITAL DR FUNERAL DIRE WITHIN 72 HOUR	UNERAL DIRE Ithin 72 hour INT: 11 itom	TAL DR PAL DIRE 72 hours	DIRE		NDING PHYSICIAN: The law requires that the death certificate be it. After this certificate has been signed by the attending physician or death with the State Dept, of Health and Mental Hygiene prior b is marked, or Item 23 shows any injury, or other traus is marked.	NONG PHYSICIAN: The law requires that the death certificate be execul: After this certificate has been signed by the attending physician and or death with the State Dept. of Health and Mental Hygiene prior to burills marked, or Item 23 shows any Injury, or other traumatic	NONG PHYSICIAN: The law requires that the death certificate be executed with this certificate has been signed by the attending physician and compile death with the State Dept. of Health and Mental Hygiene prior to burial, or is marked, or item 23 shows any injury, or other traumatic ever	ATTE	afte s	28
HOSPITAL OR ATTE FUNERAL DIRECTOI within 72 hours afte TANT: 11 item 28	IOSPITAL OR ATTE UNERAL DIRECTOI (Ithin 72 hours after INT: If Item 28	TAL OR ATTE TAL DIRECTOI 72 hours afte	DIRECTOI HOURS after 28	CTO CTO	IG PHYSICIAN: The law requires that the death certificate be let this certificate has been signed by the attending physician ath with the State Dept, of Health and Mental Hygiene prior b narked, or Itlem 23 shows any injury, or other traus	IG PHYSICIAN: The law requires that the death certificate be execute this certificate has been signed by the attending physician and rath with the State Dept, of Health and Mental Hygiene prior to burnanted, or Item 23 shows any Injury, or other traumatte	IG PHYSICIAN: The law requires that the death certificate be executed when this certificate has been signed by the attending physician and complath with the State Dept. of Health and Mental Hygiene prior to burial, or narked, or item 23 shows any injury, or other traumatic ever	NON	R: Af	- 69
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HOSPITAL OR ATTENDING PY FUNERAL DIRECTOR: After th within 72 hours after death w MANT: If item 28 is mark	IOSPITAL DR ATTENDING PA UNERAL DIRECTOR: After th ithin 72 hours after death w INT: If Item 28 is mark	TAL DR ATTENDING PI TAL DIRECTOR: After th 72 hours after death w 11 item 28 is mark	DRECTOR: After the nours after death w tem 28 is mark	ATTENDING PI CTOR: After th after death w 28 is mark	JAN: The law requires that the death certificate be fricate has been signed by the attending physician be State Dept, of Health and Mental Hygiene prior bor Nem 23 shows any Jnjury, or other traus	IAN: The law requires that the death certificate be executificate has been signed by the attending physician and re State Dept, of Health and Memal Hygiene prior to burifor 18 shows any Jajury, or other traumatic	JAN: The law requires that the death certificate be executed w trificate has been signed by the attending physician and compi te State Dept. of Health and Mental Hygiene prior to burial, or or Item 23 shows any injury, or other traumatic even	IVSIC	is ce	ed.
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FREDERICK

COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

P32 RECISTRAR'S SIGNATURE de BLE LUNA DAM SON-MINDE



1993 YEAR

3. TIME OF DEATH

02:00 A M

2. DATE OF DEATH MONTH DAY MARCH 10,

ELIZABETH WEIMER

4. SOCIAL SECURITY NUMBER

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BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

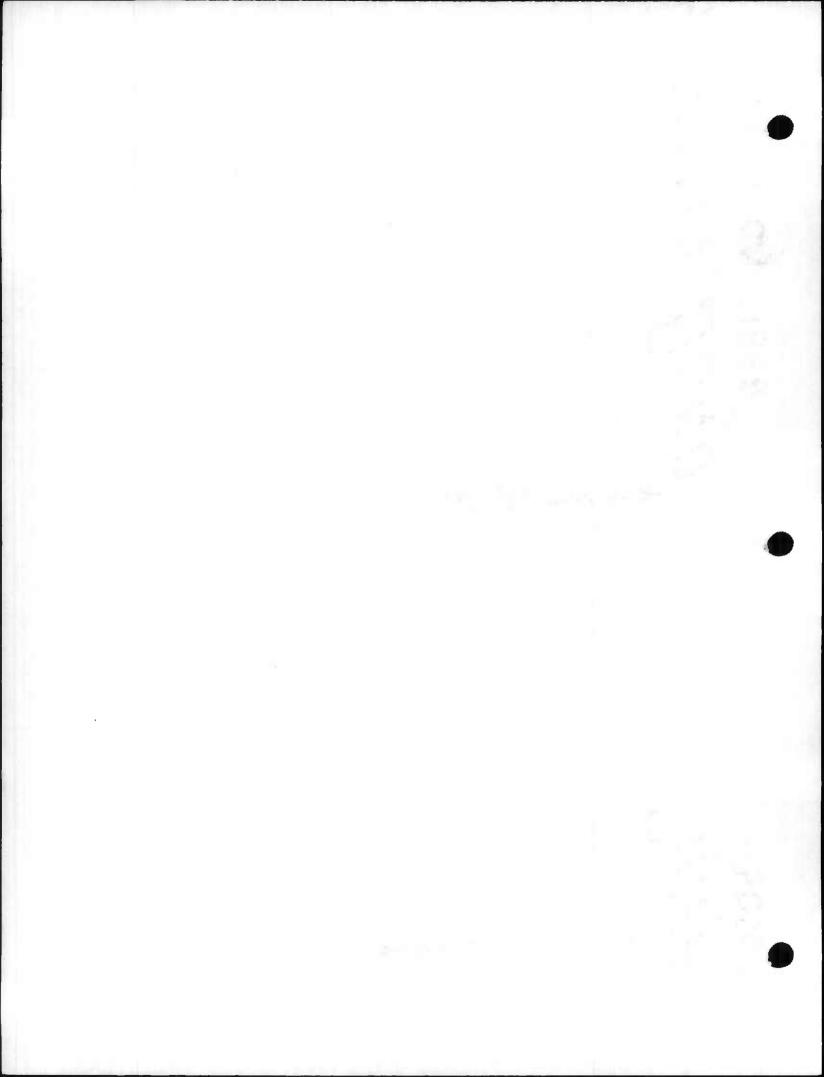
1	4. SOCIAL SECURITY NUMBER	5. 9EX	B. AGE (In yrs. les	t birthday)	IF UNDER		IF UMDER		7. DATE O			8. BIRTHPL	ACE (State or Foreign	
	220 32 4526	1 🗆 M 2 👿 F	93	YRS.	MONTHS	DAYS	HOURS	MIN.	June	19 a	1899	Marv	land	
	9a. FACILITY HAME (If not institution, giv	street and number)			9b. CITY	, TOWN	OR LOCATI	ON OF DE			9c. COL	INTY OF DEAT		
DIRECTOR	SACRED HEART HOS	PITAL				CUM	BERL	AND				ALLE	EGANY	
딩	RESIDENCE OF DECEDENT	ITY		100 00	Y, TOWN C	20.1004	FLOAL							
E		Legany		200	95								d. IHSIDE CITY LIMITS?	
_	10e. STREET AND NUMBER	rosary		Mt. Savage							1 ☐ YES 2 🔣 NO  10g. CITIZEN OF WHAT COUNTRY?			
FUNERAL	Route 1 Box	106					21545					U.S.A.		
Ž	11. MARITAL STATUS		NT EVER IN U.S.AR	MED	13.	WAS DEC	ENDENT OF HISPANIC ORIGIN? (Specify Yes or No.   14.						American Indian.	
	1 Never Married 2 Married	FORCES?	1 YES 2 N			If yes, sp	ecify Cubs	n, Mexico	in, Puerto Ri	can, etc.)	01 140-	Black, W	hite, etc.	
ВУ	3 Nidowed 4 Divorced					1 123	2 ES 140	Specify	у.				ite	
TED	15. DECEDENT'S El (Specify only highest gra	de completed)	16a. DE	CEDENT'S	USUAL O	CCUPATIO	DN ast of worldi	na	16b. I	UND OF BU	SINESS/IN	DUSTRY		
COMPLETE	Elementary/Secondary (0-12)	College (1-4 or 5	i+) #fe.											
M	6			Home	emake	er					mest:	ic		
	17. FATHER'S HAME (First, Middle, Last) Frank		7.72.1						ME (First, Mi	ddle, Maiden	Sumame)			
BE	19a. IHFORMANT'S HAME (Type/Print)		Winn				ary					оуе		
임	Annette Lashle	277							Aoute Numbe Savag			,		
- 8			20b. PLACE					10.	DATE			City or Town,	0.4	
	20g, METHOD OF DISPOSITION  1  Buriel 2  Cremation 3 Re 4  Donation 5  Other (Specify)	movel from State	cemetery, cre	matory or o	ther place	OMO	Long	3/	13/03	1V/+	Carrie	age, M	State .	
1	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE	/ 000 10	10111	22.	HAME A	ND ADDRE	SS OF FA	CILITY Th	met:	Funer	age, M	mo.	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. HAME AND ADDRESS OF FACILITY DUrst Funeral Home													
	23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest.													
	snock, or heart feilure. List only one ceuse on each line.													
	IMMEDIATE CAUSE (Final												Onset and Death	
	disease or condition a. CREBROVASCULOR ACCULOR  DUE TO (OR AS A CONSEQUENCE OF):													
z														
임	Sequentially list conditions, if any, leading to immediate	DUE TO	OR AS A CONSEC	OUENCE O	F):									
S	CAUSE (Disease or Injury	с												
늗	that initiated events resulting in death) LAST	DUE TO	DUE TO (DR AS A CONSEQUENCE OF):											
CERTIFICATION	Tooling in death, Exist	d												
	PART II. Other significant conditi	ons Contributing to	o death but not n	esulting	In the un	nderlyln	g ceuse s	given In	Part I.	4a, WAS AN			RE AUTOPSY FINDINGS	
MEDICAL	Kenal	Celen	2	1	- 0				===	PERFOR		00	AILABLE PRIOR TO IMPLETION OF CAUSE	
빌	Concerte	ve ble	ach	to	lin	p					2240		DEATH?	
	Rione	4 /11	No de	Line	212	0								
SIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	1	7 9	acc.			ACE OF D	EATH (Chi	eck only one)					
Š	1 YES 2 AND	HOSPINAL!	E3VOutpatient 3	□ DOA	OTHER 4 ☐ Nun		e S [] Re	sidence	& [] Other	Specify)				
PHYSIC	27. MANNER OF DEATH	38s. DATE O	F INJUSTY Day, Year)	28b. TW	E OF IURY	39c INJ WO	UPTY AT		28d. DE\$C	RIBE HOW I	NJURY OC	CURED		
ВУ	1 Natural 5 Pending 2 Accident Investigation				м	t 🗆 1	res 2 [	] NO						
ED	3 Suintite 6 Could not b	26s. PLACE 6 building	OF INJURY — At bor , etc. (Specify)	me, farmi,	street, fact	lory, offic	•			ION (Street I Town, State)		r or Rural Rout	Number,	
			0 01 000											
립	(Check only 1 CERTIFYING PHY													
COMPLET	one) 2 MEDICAL EXAMI	NER: On the beals of	examination and/or I	nvestigatio	on, in my o	opinion, d	leath occur	red at the	time, data a	nd place, en	d due to t	he ceuse(a) an	d manner as stated.	
ш	296. SIGNATURE AND THE OF CENTR	ER/			_		29c, LICI	ENSE NUN	48ER		29d, DA1	TE SIGNED (M	onth, Day, Year)	
00		agen	elm	7			D	20	218		•	3-12	5-9-3	
임	30. HAME AND ADDRESS OF PERSON Y	HO COMPLETED CAL	JSE OF DEATH (ITEM	27) (Type	, Print)						,			
	DR. GARY WAGON	EŔ, M.D.,	925 BIS	HOP	WALS	H RO	AD,	CUMB	ERLAN	D, MD	215	02_		
	31. DATE FILE (MAR. 12 1993	32 AEGISTR	AR'S SIGNATURE	aua.										

	REGISTRAR		CERT	<b>IFICAT</b>	E OF	DEATH	R	EG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF	DEATH			3. TIME OF DE	EATH
	William Ror	man Wilson					March	1 1	1993	YEAR	3:55	PMM
	4. SOCIAL SECURITY NUMBER	5. SEX 8. /	AGE (in yra. last birtho	fay) IF UNDE	R t YEAR	IF UNDER 24 HRS.	7. DATE OF E	HTHE	199	S. BIRTH	PLACE (State of	
-1	214-05-7889	1 X M 2 - F	76 YR	S. MONTHS	DAYS	HOURS MIN.	(Month, De			Country	y)	
	9a. FACILITY NAME (If not institution, give str	net and number		ah CIT	V TOWN	OR LOCATION OF DE		1,19		Mar TY OF D	vland	
œ	Moran Manor	soc and nambery					AIN					
2	RESIDENCE OF DECEDENT			We	scer	nport			ALI	.egar	тy	
DIRECTOR	10a, STATE 10b, COUNTY		10c.	CITY, TOWN	OR LOCA	TION				T	10d. INSIDE C	TY
<u> </u>	7.77	- 1									LIMITS?	
	WV Mines	raı.		Keyser	7 7						1 X YES 2	
FUNERAL					10	. ZIP CODE			-7		VHAT COUNTRY	7
	1515 Terri Street	5				26726			0.8	5.A.		
5	11. MARITAL STATUS	12. WAS DECEDENT EN	VER IN U.S. ARMED	13		CENDENT OF HISPAN secify Cuban, Mexica			or No-	14. RACE	— American in	ndlan,
BY	1 Never Married 2 Married	IF YES, GIVE WAR				2 NO Specify		1, 416.)		Speck	K.e.	
	3 Widowed 4 Divorced										"White	
ETED	15. DECEDENT'S EDUC (Specify only highest grade of		16e. DECEDE	NT'S USUAL O			16b. KJN	O OF BUS	SINESS/IND	USTRY		
	Elementary/Secondary (0-12)	College (1-4 or 5+)	Me. Do N	OT use retired.	)	at or working						
<u> </u>	12th		Sign	Paint	er		Ad	vert	ising	Con	apany	
COMPL	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	ME (First, Midd	le, Maiden	Surname)			
E	William Roman Wil	Lson, Sr.				M. Eva	Litze	nbur	g			
0	19a. INFORMANT'S NAME (Type/Print)		19b. MAI	LING ADDRES	SS (Street	and Number or Rural I	Route Number, (	City or Town	n, State, Zio	Code)		
2	Alma C. Wilson					Street, K				726		
	20s. METHOD QF DISPOSITION					metery, crematory or			CATION —	City or To	our Ctota	
	1 Burial 2 💢 Cremation 3 🗆 Remo	wai from State	other place)			motory, Grennatory or						2
	4 Donation 5 Other (Specify)	ENGEE	Omps Cr		_	NO ADDRESS OF FA	All ITW	Win	cnest	ær,	Virgin	ila .
	21. SIGNAL OF PONERAL SERVICE EIG	in /	-			rood McKe		nner	al Ho	ome		
	Harold Near	" Notse	nge			. Minera					π/ 26	726
	23. PART I. Enter the diseases, or co	omplications that cr	used the death.								Approx	
	shock, or heart failure. L										Interval	Between
- 1	iMMEDIATE CAUSE (Final disease or condition	0		-	1	/					Onset s	and Death
	resulting in death)	- Carcil	AS A CONSEQUENCE	01	-	ung					1	mo
		DUE TO (OR	AS A CONSEQUENC	CE OF):								
2	Sequentially list conditions,	k										
RTIFICATION	if any, leading to immediate	DUE TO (DA	AS A CONSEQUENC	CE OF):								
2	CAUSE (Disease or Injury		-72 - 22 - 32 - 32 - 32 - 32								_	
	that initiated events resulting in death) LAST	DUE TO (DA	AS A CONSEQUEN	CE OF):								
	in datas, cost											
_	PART II. Other significant conditions	a contributing to de	eth but not result	ing in the I	indarlylr	o cause given in	Part I 24	WASAN	AUTOPSY	246	WERE AUTOPS	V FINDINGS
3						g cauco giron in		PERFOR			AMULABLE PRI	OR TO
ō							_   1	YES 2	ON ∭		OF DEATH?	A CAUSE
¥							_				1 TYES 2	□ NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?					LACE OF DEATH (Ch	eck only one)					
S	1 TES 2X NO	HOSPITAL:	3/Outpatient 3 🗆 Di	DA 4 ZAN	ER: ursing Ho	ne 5 🗆 Residence	6 Other (S	pecify)				
主	27. MANNER OF DEATH	28a. DATE DF INJ	IURY 286	TIME OF		JURY AT ORK?	28d. DESCRI		NJURY OC	CURED		
	1 Natural 5 Pending	(Month, Day, 1	(bar)	M		ORK? YES 2 ND						
B	2 Accident Investigation 3 Suicide & Could not be	28e, PLACE OF It	JURY At home, fe	erm, street, fa			28f. LOCATIO	ON (Street )	and Number	or Rural F	Route Number,	_
COMPLETED	4 Homicide S Could not be	building, etc.	(Specify)				City or Ti	own, State)				
	29a. CERTIFIER 175											
릴	(Check only											
ξ	2 MEDICAL EXAMINE	R: On the basis of exam	ination and/or invest	igation, in my	opinion,	death occured at the	time, date and	f place, an	nd due to th	ne cause(e	a) and manner (	is stated.
	296. SIGNATURE AND TITLE DE CERTIFIER	1		- 0		29c. LICENSE NUI	MBER		29d. DAT	E SIGNED	(Month, Day, Ye	ver)
B	70/	Inders	on Mi	7.8.		D42669			► Ma	arch	12,199	93
2	30. NAME AND ADDRESS OF PERSON WHI	D COMPLETED CAUSE	OF DEATH (ITEM 27)	(Type, Print)				_				
	Dr. Peter J. And		51 Main		eet,	Wester	nport,	Mar	ylan	21!	562	
	31. DATE FILED (MODIF), DOI: VOAT) MAR 12 199	32. REGIS RAR'S	Cinimal.	4.00								
		-1 /2										

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an incur after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 13146,

BALTIMORE, MARYLAND 21203-3146



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit.
be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1. DECEDENT'S NAME (First,	Affeldin I not)						DEA			IEG. NO.			
1 8	BRONWEN	, Middle, Easty	WIL	LIAMS						2. DATE OF MARCH	15 DA	199	3 YEAR	3. TIME OF DEATH 02:40
	4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER		IF UNDER	24 HRS.	7. DATE OF I			6. BIRTI	IPLACE (State or Foreign
	213-18-2870	)	1 🗆 M 2 🛣 F	89	YRS.	MONTHS	DAYS	HOURS	MINN.	(Month, Da		2	Count	d.
	9a. FACILITY NAME (If not in:	stitution, give a	street and number)	09		9b. CITY	TOWN (	OR LOCATI	ON OF DE		<del>-190</del>		NTY OF D	
OR	SACRED HEAR	RT HOS						ERLA					LLEG	
5	RESIDENCE OF DEC		-		1							Less mans arry		
DIRECTOR	Md.	106. COUNT	egany *		-	ostb		TION				10d, INSIDE CIT LIMITS? 1  YES 2		
1	10e. STREET AND NUMBER							r. ZIP COD	Ε			10a, CITI	WHAT COUNTRY?	
FUNERAL	D4 4 D.	- 42									1			
Z	Rt. 1. Bo	X 13	12. WAS DECEDER	IT EVED IN II C	ADMED	21532							S.A.	
	1 Never Married 2	NO	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No- If yes, specify Cuben, Mexican, Puerto Rican, etc.)						or No-	Blec	E — American Indian, k, White, etc.			
ВУ	3 Widowed 4 Divorced IF YES, GIVE WAR OR DATES						1 VES 2 NO Specify:						Spec	White
	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5 +)						CCUPATIO	ON ast of world	ng	16b. KJN	O OF BUS	INESS/INC	DUSTRY	
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+) Home						r			Ow	n Hoi	me		
0 0	17. FATHER'S NAME (First, MI			18. MOT	HER'S NA	ME (First, Middl	le, Maiden S	Surname)						
ш	William J		_				nn Pri							
0 8	19a. INFORMANT'S NAME (7)						Route Number, (							
-	B. Betty W	_	ms		Rt.	1, B	ox 1	3, F	rost	burg,	Md.	2153	2	
	2017 METHOD OF DISPOSITI	n 3 🗌 Rem	noval from State	20b. PLAC	E AND DATE	OF DISPOS	SITION (No	ame of		DATE		ATION —		
1 1	4 Donation 5 Other		censes .	ros	tourg					3/18	Pro	stbu	rg,	Md.
	21. SIGNATURE OF FUHERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											Ma		
$\vdash$	Durst Funeral Home, Frostburg, Md.													
	23. DARD I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate interval Between											Approximata interval Between		
	Interval Betwoen Immediate Cause (Final Immediate Cause on each line.											Onset and Death		
	diseese or condition resulting in death)	<b>→</b>	a	Dun	u									3 days
CERTIFICATION	Sequentially list conditi		b. DIJE TO	OR AS A CONS	elle	air								15 years
AT	If any, leading to immed cause. Enter UNDERLY!	NG		(0.11.10.11.00.11.0		. ,.								Ì
[	CAUSE (Disease or Injustrated events	יי	DUE TO	(OR AS A CONS	EQUENCE O	F):								1
토	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST													
	04 FT 11 Oct - 12 111													
EDICAL			10 0		t resulting	in the underlying cause given in Part i.					PERFORI		24b	. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO
ĕ		inm	Made	<u></u>							YES 2	KNO		COMPLETION OF CAUSE OF DEATH?
Σ		atel										1 TYES 2 NO		
AN	25. WAS CASE REFERRED TO	MEDICAL	T											
PHYSICIAN	EXAMINER?	3 MEDICAL	HOSPITAL:	] 5010 · · · · ·		OTHE	R:		-	ock only one)				
1 ×	27. MANNER OF DEATH		1 Linpatient 2 28a. DATE Of		3 LI DOA		_	URY AT	esidence	6 Other (Sp 28d. DESCRI		III MAN OC	CHRED	
		Pending investigation	(Month, E			JURY M	WC	PRK?	] NO	aou. Degorm	DE NOW III	JUNI OC	CONED	
D BY	2 Sulaida	Could not be	28e, PLACE (	OF INJURY — At I	home, ferm,	street, faci	tory, offic	•		281. LOCATIO		nd Number	r or Rural I	Route Number,
I III I		determined	bulloting,	erc. (Specify)						City or To	wn, State)			
12	29e. CERTIFIER (Check only	IFYING PHYS	ICIAN: To the best of	my knowledge,	death occurr	ed at the t	lme, data	and place	, and due	to the cause(s	) and manr	ner as stat	ted.	
COMPLET														a) and manner as stated.
w	296. SIGNATURE AND TITLE	OF CERTIFIE						29c. LIC	ENSE NUN	IBER		29d. DAT	E SIGNED	(Month, Day, Year)
10 B	XIN (My MO) DI2532 >3-15-93													
F	30. NAME AND XDDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  GEORGE BREZA, M.D. 912 SETON DRIVE CUMBERLAND, MD, 21502													
	GEORGI 31. DATE FILED (Month, Day,	E BREZ		912 SET	ON DR	LIVE	CUMI	BERLA	ND,	MD, 21	502			
10	MAR 1	7 1001	45:	Enim	and the same									
	IIIVII T	1 199	4		-	-								

THE RESERVE

9c. COUNTY OF DEATH

10g. CITIZEN OF WHAT COUNTRY?

U.S.A

MINES.

P.A.

MD

**Allegany** 

2. DATE OF GEATH

7. DATE OF BIRTH

(Month, Day, 100)

March

IF UNDER 24 HRS.

HOURS

9b. CITY, TOWN OR LOCATION OF DEATH

Cumberland

1 I

4. SOCIAL SECURITY NUMBER

220-16-6460

MARYLAND

RESIDENCE OF DECEDENT

COLLEEN

9s. FACILITY NAME (If not institution, give street and number)

5. SEX

ALLEGANY

Memorial Hospital & Medical Center

10b. COUNTY

1 M 2 F

IF UNDER 1 YEAR

10c. CITY, TOWN OR LOCATION

WATSON

66

6. AGE (In yrs. last birthday)

YRS.

	-	
à	Pages	
ij	permit	
law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	in by the funeral director, page 5 should be detached for use as the burial-transit permit.	
attending	se as the	
6	7	
hospital	stached fo	
Ĕ	P	
stained by	should be	
80	5	
nay be	page	
9	ctor	
30e	dire	
٥.	7	
death	fune	
after	y the	TOTAL
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ĕ	8	5
24	1	inon.
within	ician and completely filled in by the funera	hart of Health and Mantal Hyrians prior to hards cremation or removal
8	E C	7
xecul	and	Prince
9	93	7
ate p	ending physicia	a nrin
in the	D D	nian
Ö	ğ	i
death	by the atte	ama
the	th.	4 12
Jat	5	200
S t	THE	alth
luire	Sig	Į
100	een	ď
3W	as been signed	hand

BALTIMORE, MARYLAND 21215-0020

2, 3 should

DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

HOSPITAL OR ATTENDING PHYSICIAN: The

ECKHART MINES FUNERAL 10e. STREET AND NUMBER GENERAL DELIVERY 21528 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-FORCES? 1 YES 2 THO 1 Never Married 2 Married If yes, specify Cuben, Mexican, Pu 1 YES 2 NO BY Specify: 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY tary/Secondary (0-12) College (1-4 or 5+) 10 HOUSEWIFE OWN HOME 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) must be notified at BE LAWRENCE BRINER HAZEL BROWN 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 RICHARD WATSON GENERAL DELIVERY **ECKHART** 20s. METHOD OF DISPOSITION
1 Description 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State MATE Eckhart 316 4 Donation 5 Other (Specify) Cemetery 21. SIGNATURE OF THERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY SOWERS FUNERAL HOME, 60 W. MAIN ST FROSTBURG medicai 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, ahock, or haart feliure. List only one cause on sech line. **IMMEDIATE CAUSE (Final** the disease or condition resulting in death) or item 23 shows any injury, or other traumatic event, DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CH CAUSE (Diseese or injury OUE TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in death) LAST PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 1 | YES 2 | W PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL FUNERAL DIRECTOR: After this certificate hi within 72 hours after death with the State D ITANT: If item 28 is marked, or item 26. PLACE OF OEATH (Check only one) HOSPITAL: **EXAMINER?** OTHER: 1 TES 2 16 Inpatient 2 - ER/Outpatient 3 - DOA 4 - Nursing Home 5 - Rasidence 6 - Other (Specify) 27. MANNER OF CEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation BY 1 YES 2 NO 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number City or Town, State) 6 Could not be COMPLETED 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL OF TO THE FUNERAL DE filed within 72 ho 2 MEDICAL EXAMINER: On the B examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER Ma D 36766 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 8 Vik Poonai M.D., P.O. Box 338, Cumberland, MD 21501 31. DATE FILED (Month, Day, Year)
MAR 17 1993 32. REGISTRAR'S SIGNATURE

The Benis

3. TIME OF DEATH

10d. INSIDE CITY LIMITS?

1 WES 2 NO

WHITE

21528

21532

21528

**Approximate** 

interval Between

Onset and Death

8. BIRTHPLACE (State or Foreign

MARYLAND

14. RACE — American Indian, Black, White, etc.

MD

MD

24b. WERE AUTOPSY FINDINGS AM/LABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?

1 TES 2 NO

29d. OATE SIGNED (Month, Day, Year)

8:18 p.

market of the more than

DIVISION OF VITAL RECORDS, P.O. BOX 68760,	BALTIMORE, MARYLAND 21215-0020
TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 🌠 hours after death. Page 6 may be retained by the hospital or attending physicis	a hours after death. Page 6 may be retained by the hospital or attending physici
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-t	illed in by the funeral director, page 5 should be detached for use as the burial-t
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	n, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	e medical examiner must be notified at once.

	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF C	EATH	1.00	3. TIME OF DEATH
	JOHN F. WIN	TERS						March	15.	1993	7:30 P. M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.	lasi birthday)	IF UNDER 1 Y		UNDER 24 HRS.	7 DATE OF B	IRTH	8. BIRTI	HPLACE (State or Foreign
	215-20-6081	1 M 2 - F	70	YRS.	MONTHS DA	AYS HO	URS MIN.	(Month, Day 12-31	-22	Man	yland
	9e. FACILITY NAME (If not institution, give a	treet end number)	*		9b. CITY, TO	WN OR LO	DCATION OF DI			COUNTY OF	
CHIESTON	229 Union Str	eet			Cum	rben	Land		1	Allego	any
	RESIDENCE OF DECEDENT  10a, STATE  10b, COUNTY									0	0
	257.000				Y, TOWN OR L		,				10d. INSIDE CITY LIMITS?
	Maryland All	egany			umben						1 A YES 2 NO
I CINETINE	The state of the s	,				10f. ZIP			10g	WHAT COUNTRY?	
	229 Union Str						1502	u.s.			
	1 Never Married 2 Married	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES 2	ARMED NO	if ye	s, specify	Cuben, Mexice	NIC ORIGIN? (Sp in, Puerto Rican	E — American Indian, k, White, etc.		
	3 Widowed 4 Divorced	IF YES, GIVE W			1 🗆	YES 2X	NO Specify	y:		Spec	"y: White
	15. DECEDENT'S EDU	CATION	-	DECEDENT'S	USUAL OCCU	IPATION		165 KINI	OF BUSINES	S/INDUSTRY	
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +		(Give kind of work done during most of wo life. Do NOT use retired.)							
	Unknown			elf-	emplo	ved		Pa	intin	a	
	17. FATHER'S NAME (First, Middle, Last)						MOTHER'S NA	ME (First, Middle		~	
	John F. Winter	s, Sr.					Made	lyn He	avner		
	19e. INFORMANT'S NAME (Type/Print)		T	19b. MAILING	ADDRESS (St	treet end N	umber or Rural i	Route Number, C	ity or Yown, Stat	re, Zip Code)	
	Donna Tabler			519	Beal1	St	reet-0	Cumber	land,	MD	21502
	20a. METHOD OF DISPOSITION 11/2 Burlel 2 Cremation 3 Rem	med from State	20b. PLAC	EANDDATE	OFDISPOSITIO	N (Neme o	1	DATE	20c. LOCATIO	N — City or To	own, State
	4 Donation 5 Other (Specify)		MSVC	-Roc	ky Ga	D	3-22-5	93	Fli	ntsto	one, MD
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			22. NAS	ME AND A	DORESS OF FA	CILITY	F	. 1 4	ne, P.A.
	Word 1 9	Leacher	unho	202 Greene				uren 1 S+ C.	ne, 1.n.		
7	23. PART i. Entar the diseases, or o	complications that	caused tha	death. Do i	not anter the	moda	of dving, suc	h aa cardiac	or respiretor	Approximata	
İ	ahock, or heart failure.	List only one cau	se on each li	na.						,,	Intarval Between
	iMMEDIATE CAUSE (Final disease or condition	ARTER	10501	5007 <i>1</i>	C 1151	107	27051	22			Onset and Death
ij	resulting in death)		(OR AS A CONS			1/8/	DISCH.	JC			
	Sequantially list conditions, if any, leading to immediate	DUE TO	OR AS A CONS	SEOUENCE O	F):						
	CAUSE (Disease or Injury	B									
	that initiated events resulting in death) LAST	DUE TO	(OR AS A CONS	SEOUENCE O	F):						
	resulting in death) CAST	d									
ı	PART if. Other aignificant condition	a contributing to	death but no	t reaulting	in the under	rlying ca	usa given in	Part i. 24a.	WAS AN AUTO	PSY 24b	. WERE AUTOPSY FINDINGS
									PERFORMED?		AVAILABLE PRIOR TO COMPLETION DF CAUSE
								_   ' -	YES 2 N	°	OF DEATH?
											1 YES 2 NO
	25. WAS CASE REFERRED TO MEDICAL				2	26. PLACE	OF DEATH (Ch	eck only one)			
	EXAMINER?	HOSPITAL:	ER/Outpatient	3 DOA	OTHER:		1	8 Other (Spe	and the		
1	27. MANNER OF DEATH	28e. DATE OF	INJURY	28b. TIM	E OF 28c	c. INJURY	1		E HOW INJURY	OCCURED	
į.	Netural 5 Pending	(Month, De	lly, Year)	INJ	M 1	WORK?	2 🗌 NO	NIT COMMENT			
ı	2 Accident Investigation 3 Suicide a Could not be	28e. PLACE OF	F INJURY — At	home, farm,	streel, factory,	office		28I, LOCATION	(Street and Nu	imber or Rural I	Route Number,
	4 Homicide determined	ouncing,	etc. (Specify)					City or Tow	vn, State)		
1	29a. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of	my knowledge.	death occum	ed at the time	data and	place, and due	In the cause(s)	and manner a	a stated	
1	CENTIFIEN 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner es stated.  MEDICAL EXAMINER: On the examination end/or investigation, in my opinion, death occurred at the lime, date end place, and due to the cause(e) and manner es stated.										
H	296. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)										
	Xal /		_				D0915		29d.	3-/	5 – 9 3
	30. NAME AND ADDRESS OF PERSON WHI	COMPLETED CAUS	E OF DEATH (II	TEM 27) (Type	Print)		/ - /	′			, , ,
	Paul Snow, M.D					Thi	nd St	., Cumi	berlai	rd, MD	2/502
1	31. DATE FILED (Month, Day, Year)							7 = 4			
	31. DATE FILED (Month, Day, Your)  32. FGISTMAN'S SIGNATURE										

ALL BOLLET STORY

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

REGISTRAR		C	ERTIF	ICATE	OF DEATH		REG. NO	Ο.			
1. DECEDENT'S NAME (First, Middle, Last)  LILA		YARB	ROUGH				TE OF DEATH	2 I	953	3. TIME OF DEATH	
4. SOCIAL SECURITY NUMBER	5. SEX 6	. AGE (In yrs. I		IF UNDER 1	YEAR IF UNDER 24 (	3	TE OF BIRTH			PLACE (State or Foreign	
243-36-3618	1 □ M 2 X 🖟	63		-		(Mr	26-19	29	Country	th Caro	
9e. FACILITY NAME (If not institution, give s	street and number)			9b. CITY, T	OWN OR LOCATION	OF DEATH		9c. COL	INTY OF DE	EATH	
Memorial Hospit	al & Medio	cal Cer	nter	Cum	berland			Al	legar	ny	
10a. STATE 10b. COUNT	Υ		10c. CIT	Y, TOWN OR	LOCATION					10d. INSIDE CITY	
Maryland Alle	egany		01	dtowr		710 CODE			LIMITS?		
Route 1					2155	21555			10g. CITIZEN OF WH		
11. MARITAL STATUS  1 Never Married 2 Married  3 Widowed 4 Divorced	12. WAS DECEDENT I FORCES? 1 _ IF YES, GIVE WAR	YES 2	RMED NO	- If y	es, specify Cuban, N	ENDENT OF HISPANIC ORIGIN? (Specify Yea or No- cify Cuban, Maxican, Puerto Rican, etc.)  2 N NO Specify:			Black, White, etc. Specify:		
15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	18a. D	18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of w			ON 16b. KIND OF BUSINESS			DUSTRY	White	
Elementary/Secondary (0-12) 1 2	12						Hor	20			
17. FATHER'S NAME (First, Middle, Last)	110	ousew	7110	18. MOTHER	'S NAME (Firs	t, Middle, Maide					
William G. Bel						nitfor					
19a. INFORMANT'S NAME (Type/Print)	1			Street and Number or				p Code)			
Georgene McLau	Georgene McLaughlin					aryla	and 21	555			
20e. METHOD OF DISPOSITION  1 □ Burial 2 \( \tilde{\chi} \) Cremation 3 □ Rem  4 □ Donation 5 □ Other (Specify)	oval from State	20b. PLACE	AND DATE OF	of DISPOSITI	on(Name of	3-15	20c. L	deri	City or Toy	vn, State	
	CENSEE	1.000	114 / 0	22. NA	ME AND ADDRESS	OF FACILITY					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  A Donation 5 Other (Specify)  22. NAME AND ADDRESS OF FACILITY  Leasure—Stein, Inc. 230 Baltimore Av.  Cumberland, Md. 21502											
ahock, or heart failure. List only one cause on aach line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):											
if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other aignificant condition	a contributing to de	eath but not	rasulting (	in the unde	riying cause give	n in Part i.	24a. WAS A PERFO	RMED?		WERE AUTOPSY FINDI AMAILABLE PRIOR TO COMPLETION DE CAU OF DEATH? 1 YES 2 NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER?					28. PLACE OF DEAT	H (Check only	one)			···	
1 TYES 2 KNO	HOSPITAL:	R/Outpatient	3 🗆 DOA	OTHER:	Home 5 - Reside	nce 8 🗆 Ot	her (Specify)				
27. MANNER OF DEATH  19 Netural 5 Pending	28a. DATE OF IN (Month, Day,		28b. TIM	E OF 28	ic. INJURY AT WORK?	28d. D	ESCRIBE HOW	INJURY OC	CURED		
2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF II	NJURY — At h	ome, farm, s			28f. L.	OCATION (Street ty or Town, State		r or Aural Ad	oute Number,	
29a. CERTIFIER (Check only one)  2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.										and manner as state	
29b. SIGNATURE AND TITLE OF CERTIFIER					29c. LICENSI		_			(Month, Day, Year)	
games De	782	om			D 370			•		193	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  Robert Duggan M.D., Memorial Hospital Medical Bldg., Cumberland, MD 21502											
31. DATE FILED (Month, Day, Year) MAR 17 1993	32. BEISTRAN	SIGNATURE	guena		0	,		,			



BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Proves filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

DHMH-18 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC			MENTAL HYGIE REG. N	/	Browned				
	1. DECEDENT'S NAME (First, Middle, Last)	JOHN	ZANDARSI	KI		2. DATE OF DEATH MONTH	DAY 93	3. TIME OF GEATH				
	4. SPICIAL SECURITY NUMBER  215-12-5404  9e. FACILITY NAME (If not institution, give s	1 XM 2 - F	72 YRS. MO	NTHE DAYS	IF UNDER 24 HRS. HOURS MIN,	7. DATE OF BIRTH (Month, Day, Year) 1/1/19	21	BIRTHPLACE (State or Foreign Country) Maryland				
CTOR	93/ Faleul	Kul Rud	, ,	-	IT LOCATION OF DE	treet						
DIRECTOR	Maryland 106. COUNTY	Harford	10c. CITY, T		eet			10d. INSIDE CITY LIMITS? 1 YES 2 X NO				
FUNERAL	10a. STREET AND NUMBER  931 Feder  11. MARITAL STATUS	al Hill Ro			211			U.S.A.				
B	1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	If yes, spe	ENDENT OF HISPAP ecify Cuben, Mexica 2 NO Specify	NC ORIGIN? (Specify in, Puerto Rican, etc.) y:	Yes or No- 14	I. RACE — American Indian, Black, White, etc. Specify: Caucasian				
COMPLETED	15. DECEDENT'S EDUI (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	16a. DECEDENT'S USI (Give kind of work life. Do NOT use re	done during mo: tired.)	DN st of working	16b. KIND OF	BUSINESS/INDUS					
NAP CE	17. FATHER'S NAME (First, Middle, Last)		Fai	mer			Farmin	g				
E CO	Stanley	Zandars	ki			ME (First, Middle, Meid enni e		kowska				
TO B	19a. INFORMANT'S NAME (Type/Print)	<u> </u>		DRESS (Street a		Route Number, City or						
	Anna Clark		same	as #	10							
	26. METHOD OF DISPOSITION 1.0 Burlal 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	H	PLACE AND DATE OF DETAIL OF THE PLACE AND DATE OF THE PLACE AND DA	ry Ce	metery	3/22 D	LOCATION — CIR undalk	y or Town, State  Maryland				
246	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  Kurtz Funeral Home  Jarrettsville, Maryland											
ERTIFICATION TO BE COM	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):											
CERTIFIC	CAUSE (Disease or Injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):											
MEDICAL	PART II. Other significant condition	s contributing to death b	ut not resulting in t	he underlying	; ceuse given in	PERF	AN AUTOPSY ORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2 NO				
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			ACE OF OEATH (Ch	eck only one)		1				
	YES 2 NO	1   Inpatient 2   ER/Outp		THER:  Nursing Hom	5 Residence	6 Other (Specify)						
H	27. MANNER OF DEATH	28a, DATE OF INJURY (Month, Day, Year)	28b. TIME O	WO	RK?	28d. OEŞCRIBE HO	W INJURY OCCU	REO				
	### Accident Investigation    3	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm, streetly)	it, factory, office		28t. LOCATION (Stre City or Town, Str	et end Number or	Rural Route Number,				
COMPLET		CIAN: To the best of my knowl R: On the basis of axamination						cause(s) and menner as stated.				
TO BE COMPLE	296. BIGMATUME AND TITLE OF CENTIFIER	alp MD			29c. LICENSE NUM			IGNED (Month, Dey, Year)				
-	21. DATE FILED (Month), Day Years	5 - CO LF	ATURE	*0	20/3	selling	en, M	1 21034				
	MAR 23 93	gulia Davi	Son-Handell									

4:00

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

Specify:

1 YES 2 NO

White

21222

Approximate interval Between

Onset and Death

24b. WERE AUTOPSY FINDINGS

AVAILABLE PRIOR TO COMPLETION OF CAUSE

1 | YES 2 | NO

8. BIRTNPLACE (State or Foreign

Va.

Baltimore

PM

1993

REG. NO

2. DATE OF DEATH

FOR

1 -

STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

Dawn

Angel

Eleanor

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· VITAL RECORDS,	
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DIVISION OF	
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4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF LINGER 1 YEAR IF IMPER 24 HIRS 7 DATE OF BIRTH (Month, Dey, Year) 1/24/1923 70 212-22-1079 1 M 2 X F VRS use as the burial-transit permit, Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c COUNTY OF DEATH 2500 B Linwood Rd. DIRECTOR Parkville 10b. COUNTY 19c. CITY, TOWN OR LOCATION Md. Baltimore Parkville FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 2500 B Linwood Rd. U.S.A. 21234 after death. Page 6 may be retained by the hospital or attending physician, 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-BALTIMORE, MARYLAND 21215-0020 1 Never Merried 2 Merried If yee, specify Cuben, Mexican, Puerto Rice
1 ☐ YES 2 NO Specify: IF YES, GIVE WAR OR DATES ВУ 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY -joj Elementary/Secondary (0-12) College (1-4 or 5+) detached 11th Homemaker once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First Middle Meider Sumame) the funeral director, page 5 should be F Robert York Tickle BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ACORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1980 William Angel Seales Rd. Dundalk Maryland 21222 eg 20a. METHOD OF DISPOSITION
1 1 8 Burlel 2 Cremation 3 Re
4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Nama of 20c. LOCATION — City or Town, State OATE Must Parkwood 4/9 Baltimore 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Dundalk 7110 Sollers Pt. Rd. Dundalk Md. olt medicai filled in by t 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart fellure. List only one cause on such line. 50 **IMMEDIATE CAUSE (Finel** cheral has been signed by the attending physician and completely fills Dept. of Health and Mental Hygiene prior to bunal, cremation, the disease or condition resulting in death) myotrophic within event. DUE TO JON AS A CONSEQUENCE OF executed traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury pe certificate other OUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST 10 death c 23 shows any injury, PART ii. Other aignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY MEDICAL that t PERFORMED? 1 TES 2 NO PHYSICIAN: AMP. 25. WAS CASE REFERRED TO MEDICAL The Hem 26. PLACE OF DEATN (Check only one) After this certificate I HOSPITAL: OTHER: PHYSICIAN: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA se 5 - Residence 6 - Other (Specify) 0 26e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 26b. TIME OF 28c, INJURY AT 26d. DESCRIBE NOW INJURY OCCURED is marked, 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident OR ATTENDING 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 26t. LOCATION (Street and Number or Rural Route Number, City or Town, State) DIRECTOR: A hours after d litem 28 is 6 Could not be COMPLETED 4 Homicide 29e. CERTIFIER

// Chack only

1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner se stated. FUNERAL ( HOSPITAL Ξ 2 MEDICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, death MPORTANT: 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Morph, Day, Year)

4/6/23 DI SYZ BE 품 THE 223 9 WHO COMPLETED CAUSE OF DEATH UTEM 27) (Typo, Pring ech Keeven Kla 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

Savidson-Randale

06 1993

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

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permit. Pages 1, 2, 3 should PHYSICIAN: The law requires that the death certificate be executed unfor 2 amounts after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit p with the State Dept. of Health and Mental Hydrene prior to bunal, cremation, or removal.

\*\*Red, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO THE HOSPITAL OF ATTENTY
TO THE FUNERAL DIFFERENCE
De filed within 72 hos
IMPORTANT: If Item

BALTIMORE, MARYLAND 21215-0020

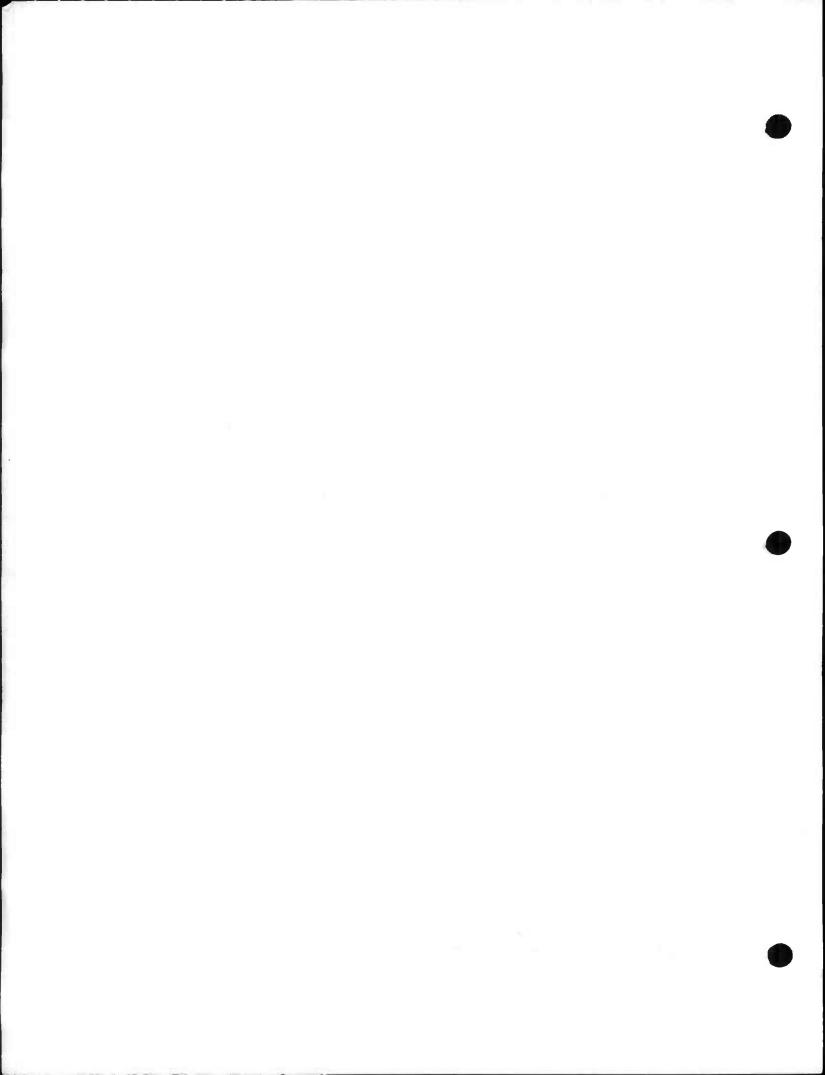
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	FOR		CTATE OF B	AADVI AAID	/ DED.						. Take Ear	9	3 (	19570
	1 - STATE REGISTRAR		STATE OF M		ERTIF					MENTA	REG. NO.			
	1. DECEDENT'S NAME (Flist) ALMA	Middle, Last)									L 2, 1	YEAR	3. TIME OF DEATH 4:30 A <sub>M</sub>	
	4. SOCIAL SECURITY NUMBER 242-54-25		5. SEX	6. AGE (In yrs. I	est birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS.	7. DATE (Mont)	OF BIRTH 2 Day, Year) 2 - 24 -	45	8. BIRTH	PLACE (State or Foreign
OR	THE JOHNS			AL	96. CITY, TOWN OR LOCATION OF DE BALTIMORE CITY						***	TIMO	RE CITY	
ECT	RESIDENCE OF DEC	10b. COUNTY	Y	10c. CITY, TOWN OR LOCATION									10d. INSIDE CITY	
FUNERAL DIRECTOR	MD			Baltimo							LIMITS?			
ERAI	100. STREET AND NUMBER	clay	St.	St.			10f. ZIP CODE 21218					ZEN OF W	HAT COUNTRY?	
BY FUN	11. MARITAL STATUS 1 X Never Married 2 3 Widowed 4 Divo	Married	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	RMED (NO	MED 12 MBS DESCRIPTION OF LUCKE				ANIC ORIGIN? (Specify Yea or No— 1-can, Puarto Rican, etc.)				— American Indian, , White, etc.	
밀	15. DEC (Specify only	EDENT'S EDU	CATION completed)	16a. D	ECEDENT'S	USUAL OC	CCUPATI	ON opt of working	na.	16b.	KIND OF BUS	SINESS/IND		Black
COMPLETED	Elementary/Secondary (0		College (1-4 or 5	-) "	louse	se retired.)		out or worki	-9					
	17. FATHER'S NAME (First, M	iddle, Last)						18. MOT	HER'S NA	ME (First, A	Aiddle, Maiden	Surname)		
TO BE	19a, INFORMANT'S NAME (7)			1							per, City or Town			
	Anthony								St./	-	timor			
72	29a. METHOD OF DISPOSITI 1X Buriel 2 Crematic 4 Donation 5 Other	cemetery, c	placeand date of disposition (Name of tery, cremetory or other place) Count Zion Cemetery						DATE 20c. LOCATION — City or Town, State Lansdowne, MD					
	21. SIGNATURE OF FUNERAL	SERVICE LIC	CENSEE -	On.		22. 1	NAME A	ND ADDRE	SS OF FAC					of Ac.
	23. PART I. Enter the di	seasea, or o	complications that	t caused the d	leath. Do i	ot enter	tha mo	ode of dy	ing, suci	h aa card	liac or reaple	ratory err	eat,	Approximata
	IMMEDIATE CAUSE (Fin disease or condition	al.	List only one cau			- (v)	e	1. 1.	. 0 7	<b>D</b> 1.	2 -0			Onset and Death
	resulting in death)		6. <u>50</u>	(OR AS A CONSI	EOUENCE O	5 U	Ne	20r	al 1	DIE	ea			Lhours
NO	Sequentially list conditi		b. DUE TO	LASE OR AS A CONSI	ah'Z	BI	rec	rat	Car	uce	1			lyear
CAT	If any, leading to immed cause. Enter UNDERLY! CAUSE (Disease or Inju	NG	c	or eas	+ C	me	er	_						3 48as
CERTIFICATION	that initiated events resulting in death) LAS		DUÉ TO	(OR AS A CONSI	EOUENCE O	F):								
_	PART II. Other significa	nt condition	s contributing to	death but not	resulting	In the un	derivin	O CRUSO	alven in	Part I	24a, WAS AN	ALITOROV	Lan	WEST ALTERNATION OF THE PARTY O
PHYSICIAN: MEDICAL						in the on	ucriyar	y cause (	given m	-	PERFOR	MED?		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
. ME										_				1   YES 2 10110
CIAN	25. WAS CASE REFERRED TO EXAMINER?	MEOICAL,	HOSPITAL:					LACE OF O	EATH (Che	ick only on	•)			
IYSI	1 VES 2 NO		1 Inpatient 2 28a. DATE OF	ER/Outpatient	3 DOA		ing Hom	10 5 Re	sidence	_				
BY PI	1 Natural 5 🔲	Pending nveatigation	(Month, D	ny, Ybar)	INJ	M	1 🗆 '	YES 2	ON [	28d. OE\$	CRIBE HOW IN	JURY OCC	URED	
ETED		Could not be letermined	28e. PLACE O building,	F INJURY — At h etc. (Specify)	ome, farm,	street, facto	ory, offic			28t. LOCA	ATION (Street a or Town, State)	nd Number	or Rural Ro	oute Number,
COMPLETED	one) 2 MEDI	CAL EXAMINE												end manner as stated.
B	29b. SIGNATURE AND TITLE	Cu	Sont					29c. LICE	NSE NUM	BER 67	6	29d. DATE	SIGNED	(Month, gay, Year) Z/93
5	30. NAME AND ADDRESS OF MARC	PERSON WH	BUT	LER OF OEATH (ITI	ЕМ 27) (Туре,	Print)	Jr	XHN	5 4	LOPK	INS	1	105	PITAL
	31. DATE FILED (Month, Day, 1) APR 06			R'S SIGNATURE					- 11	-1.		, ,	, 00	·IM
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	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
	ICIA	Certi	the	0
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	FOR	STATE OF	MADVI AND / DED	DTMENT OF			93	09571	
	1 - STATE REGISTRAR		MARYLAND / DEPA CERTI	FICATE O	F DEATH	MENTAL HYGIEI REG. NO			
	1. DECEOENT'S NAME (First, Middle, JEROME	J.	В	RISBON	, Jr	2. DATE OF DEATH	<b>M</b> 9	year 9:59 P <sub>M</sub>	
	4. SOCIAL SECURITY NUMBER 218-86-4546	5. SEX	6. AGE (In yrs. lest birthde	MONTHS DAY		7. DATE OF BIRTH (Month, Day, Year) 8-7-1968	- 1	BIRTHPLACE (State or Foreign Country)	
æ	Sa. FACILITY NAME (If not institution, give street and number)			96. CITY, TOWN OR LOCATION OF DEATH BALTIMORE			9c. COUNTY OF DEATH		
16	SINAI HOSPI'	BALII	MORE						
DIRECTOR	10a. STATE 10b. Co	106. COUNTY  106. COUNTY  106. COUNTY  106. COUNTY  106. COUNTY  106. COUNTY  106. COUNTY  106. COUNTY  106. COUNTY  106. COUNTY  107. YES 2 \( \text{N} \)							
FUNERAL	10s. STREET AND NUMBER				10f. ZIP CODE			10g. CITIZEN OF WHAT COUNTRY?	
Ü	4904 Chalgrov		21215			USA			
B	11. MARITAL STATUS  1 X Nover Married 2 Merried  3 Widowed 4 Divorced  12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES			13. WAS E If yes, 1 🔲 Y	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.)  1  YES 2  NO Specify:  Specify:			4. RACE — American Indian, Black, White, etc. Specify: Black	
COMPLETED	15. DECEOENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5 +)  College (1-4 or 5 +)						ВТЯУ		
OM	17. FATHER'S NAME (First, Middle, Las	")			18 MOTHER'S NA	ME (First, Middle, Melder	Summer		
BE C	Jerome J. Brisbon, Sr					a Martin Brisbon			
TO E	19a. INFORMANT'S NAME (Type/Print)				at and Number or Rural I	Route Number, City or Tov	vn, State, Zip Co	ode)	
	Jerome J. Brisbon, Sr 4904 Chalgrove Avenue Baltimore, Md 21215								
21. SIGNATURE OF FUNERAL SERVICE LICENSES						1	OATE 20c. LOCATION — City or Town, State  893 Randallstown, Md		
						anuari	Stown, Mu		
	March F/H West 4300 Wabash Avenue								
	23. PART I. Enter the diseases, or complications that coused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heert feliure. List only one couse on each line.  IMMEDIATE CAUSE (Finel disease or condition reaulting in death)  Due to (or as a consequence of):								
1: MEDICAL CERTIFICATION	Sequentially list conditions, If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  b. OUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.								
	PART II. Other significent cond	in the underlying cause given in Part i.		Part I. 24a. WAS AN PERFOI	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2  NO			
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  ACCUSED BY								
PHYSICIAN:	1 VES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 8 Other (Specify)								
ВУ РН	1 Natural 5 Pending 0 4 0 1 9 3 9 IN 9 IN 9 IN 9 IN 9 IN 9 IN 9 IN			131	NJURY AT WORK? YES 2 NO		SCRIBE HOW INJURY OCCURED BJECT WAS SHOT		
8	3 Suigide 8 Could not be determined 28e. PLACE OF INJURY — At home, ferm, to building, stc. (Specify) STRE				ET 281. LOCATION 3°C 0 6°C		Street and Number or Rural Route Number,		
COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) end menner se stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(e) end menner se stated.								
TO BE C	296. SIGNATURE AND STILE OF CERTIFIER  OF CHUKENI)			29c. LICENSE NUMBER O. C. M. E.			29d. DATE SIGNED (Month, Day, Year)  • 04/02/93		
111 Penn Street, Baltimore, Maryland								nd 21201	
	APR 06 1993	gula Davido	AR'S SQUATURE-						



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THE HOSPITAL OR ATTENDING F THE FUNERAL DIRECTOR: After I filed within 72 hours after death

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31. DATE FILEO (Month, Way, Year)

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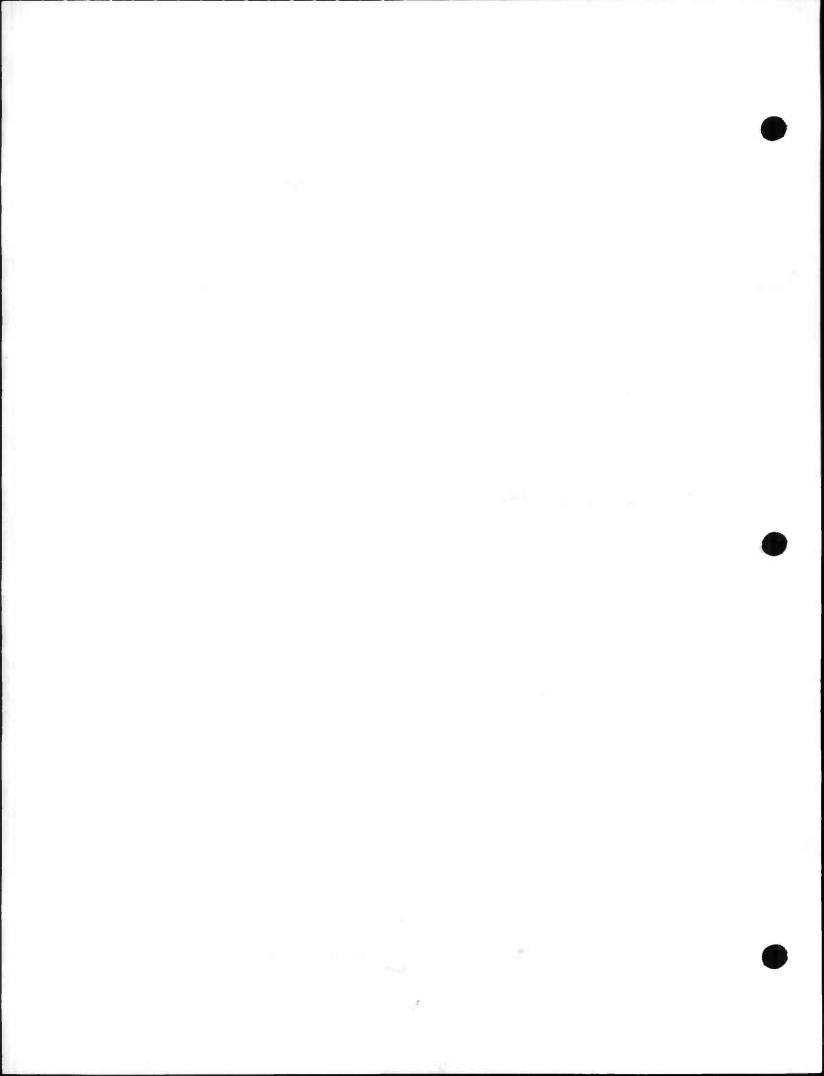
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE APR - 6 1993

93 09572 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) ULMAN BRITOWICH SYLVIA 3. TIME OF DEATH YEAR BRITOUIC D3 YLVIA 6:369m 30 4. SOCIAL SECURITY NUMBER S. SEX 6. AGE (In yrs. last birthday) 7916 IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreig 220 20 1 M 2 DF 80 YRS. DAYS HOURS MARYLAND 17. 9a. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF CEATH BERT DIRECTOR MEDIC CEVE MORE RESIDENCE OF DECEDENT 10b. COUNTY IDC. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE 1 X YES 2 NO FUNERAL 10s. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21215 3615 FORDS LA., APT. 209 USA WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
 N was exactly Cuban. Mexican, Puerto Rican, etc.) 12. WAS DECEOENT EVER IN U.S. ARMEO FORCES? 1 TYES 2 THO IF YES, GIVE WAR OR DATES X 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexican,

1 YES 2 NO Specify: 1 Never Married 2 Married BY Specify: 3 Widowed 4 Divorced WHITE COMPLETED 15. DECEOENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION (Give kind at work done during most of working life. Do NOT use retired.) 16h KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) TEACHER EDUCATION 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) LOUIS ULMAN ROSE LOKOM 띪 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 CAROL LEVY 5902 31ST AVE HVATTSVILLE, MD 20782 615 9 METHOD OF DISPOSITION
Burlel 2 Cremation 3 Removal from State 20c. LOCATION - City or Town, State 1 N Buriel 2 Cremation 4 Donation 5 Other (Specify) TSU E BETH TFILOH 4/1/93 BALTIMORE, MD ATURE OF FUNERAL SERVICE LICENSEE 22 SOLE ANDEROTINSON CHITYBROS., INC. 21215 6010 REISTERTOWN RD. BALTO., MD 23. PART h Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate heert failure. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition\_ SEPSIS resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentielly list conditions, QUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other significent conditions contributing to deeth but not recuiting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? PERFORMED? shows any 1 YES 2 NO 1 YES 2 NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER:
4 | Nursing Home 5 | Residence 8 | Other (Specify) 1 Department 2 ER/Outpatient 3 DOA 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCUREO marked, 5 Pending Investigation 1 Natural BY 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — Al home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 15 6 Could not be COMPLETED 4 🔲 Homicide Hem CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(a) and menner as stated. TO THE HOSPITAL TO THE FUNERAL (De filed within 72 h (Check only one) 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, de 296. SIGNATURE AND TITLE OF CERTIFIER BE 29d, DATE SIGNED (Month, Day, Year)

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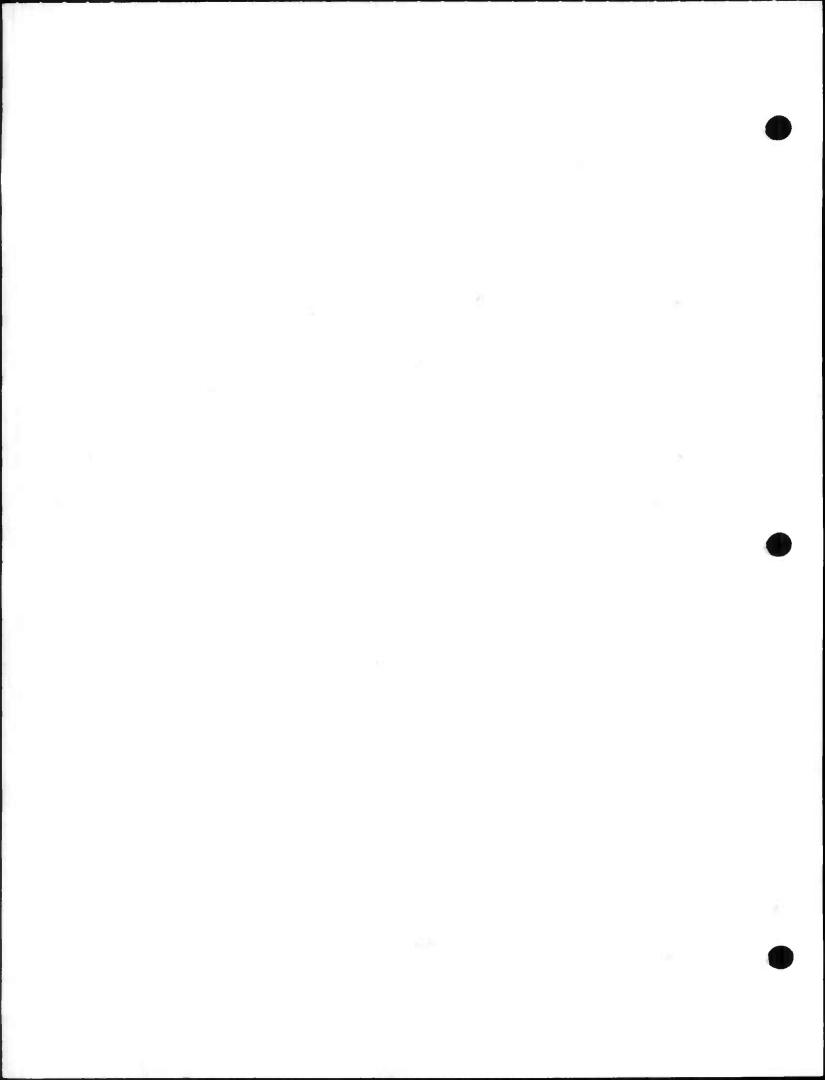
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	THE HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24	THE HINEHAL DIRECTOR: After this certificate has been signed by the attending physician and completely fill	M fled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation	IMPORTANT. If them 28 is marked, or item 23 shows any injury, or other traumatic event, the
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DAY Chester Barnes 04 03 1993 2:07 P.M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Country) a 1921 O Bound De sent 71 HOURS 1 🔯 M 2 🗌 F 227 12 0504 YRS 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 1129 N Fulton Avenue Baltimore City 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Balto. Md. 1 XYES 2 NO 100. STREET AND NUMBER 1129 N. Fulton Ave. FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? USA 21217 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuban, Mexican, Puarto Rican, etc.)

1 YES 2 NO Specify: IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced 45-48 Black COMPLETED 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) Auto Mechanic 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Beatrice Thrower Barnes Joshua BE 19a. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Gode) 21215 5 Geraldine Johnson 20a METHOD OF DISPOSITION

1 Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Carry reinsportine Forest V.A. Owings Milis, Md. 4-8 4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE James A. Morton & Sons Morton a ames Balto., Md. 21217 Laurens St. 1701 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart feiture. Liet only one cause on each line. **Approximate** interval Between **IMMEDIATE CAUSE (Finel Onset and Death** Cardiovascular disease or condition\_ Mtherosclerotic resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 X YES 2 NO 4 ☐ Nursing Home 5 A Residence e ☐ Other (Specify) 26a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 26b. TIME OF INJURY 28c. INJURY AT WORK? 26d, DESCRIBE HOW INJURY OCCURED 5 Pending Investigation 1 Natural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, term, atreet, factory, office building, atc. (Specify) 3 Suicide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 8 Could not be 4 Homicide H 29a. CERTIFIER

(Chark only 1 CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. COMPL 2 XMEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Yber) bute mo O.C.M.E. 04/04/1993 5 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) AND THE BEASING THE RE Penn Street, Baltimore, Maryland 21201



FOR

PART I, 27, 28a, b, c, d, e, f PER MEO G-698 (
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 23

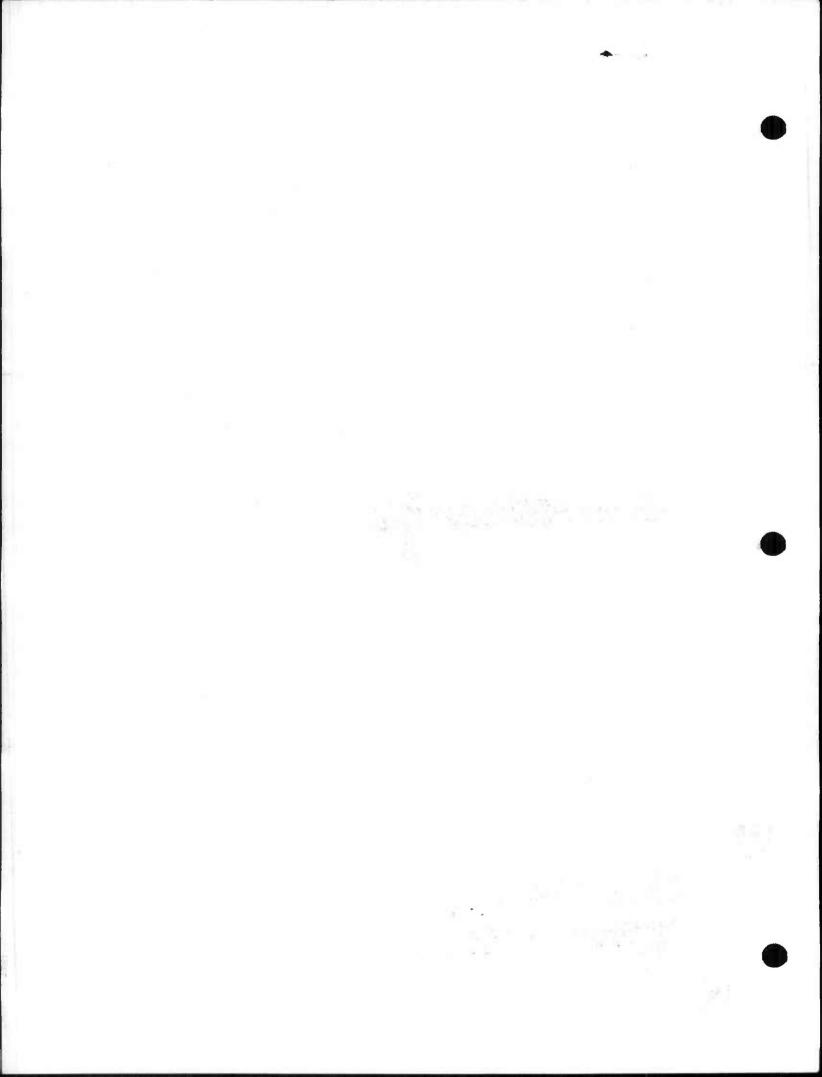
	1 - STATE REGISTRAR		C	ERTIF		F DEATH	INITIA INT	REG. NO			
	1. DECEDENT'S NAME (First, Middle, Lest) HEIDI		LYI	NNE	E	BYERS	MONTH		AY 1.00	YEAR	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	5, SEX	6. AGE (In yrs. la	at hirthday)	IF UNDER 1 YEA	R IF UNDER 24 HRS.	0.3	29	199		12:14 PM  ACE (State or Foreign
	004-70-7485	1 □ M XX F	31	YAS.	MONTHS DAY		(Month)	-30-6	1 1	Country)	land
DIRECTOR	99. FACILITY NAME (If not institution, give s  CARROLL COUNT  RESIDENCE OF DECEDENT		TAL		WEST!	M OR LOCATION OF D	EATH		9c. COUNT	OLL	гн
<u>ي</u>	10a. STATE 10b. COUNTY	Y		10c. CIT	Y, TOWN OR LO	CATION				10	od, INSIDE CITY
급	Maryland Ca	arroll		1	Westmi	nster				1	LIMITS?  X YES 2 NO
4	10a. STREET AND NUMBER					101. ZIP CODE			10g. CITIZI	EN OF WHA	AT COUNTRY?
FUNERAL	10 Washington I						United				
ED BY FU	1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT FORCES? 1 [ IF YES, GIVE WA	YES 2	2 NO If yes, specify Cuban, Maxican, Puar							
	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DI	ECEDENT'S	USUAL OCCUPA	ATION most of working	16b.	KIND OF BUS	SINESS/INDU		
	Elementary/Secondary (0-12)	College (1-4 or 5+)	) III	Do NOT us	e retired.)	sistant	١,	Nursing Home			
COMPL	17. FATHER'S NAME (First, Middle, Last)		140	AT ST	ig Ass	18. MOTHER'S NA				One	
BEC	Carroll Richard	d Byers							Dea	n	
	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS (Stre	et and Number or Rural					
임	Phyllis M. Bye	rs	:	30 L	ocust	St, Apt	507	, Wes	tmin	ster	, MD2115
	20e, METHOD OF DISPOSITION 1.83 Burlei 2 Cremetion 3 Rem	oval from State	20b. PLACE	AND DATE	F DISPOSITION	(Name of	DATE	20c. LO	CATION — CI	ity or Town,	, State
	4 Donation 5 Other (Specify)	OCHOPE .	Lake	view		rial Par		2 Sy	kesvi	ille	, MD
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY Myers Funeral Home 21157 91 Willis Street, Westminster, MD.  23. PART I. Enter the diseases, Dr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,   Approximate										
NOI	shock, or heert failure. List Dniy Dne cause or each line.  IMMEDIATE CAUSE (Fine) disease pr condition resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):  B. DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST  DUE TO (OR AS A CONSEQUENCE OF):  d.										
MEDICAL	PART ii. Other significent condition	e contributing to o	death but not	resuiting (	n the Underly	ring ceuse given in	Part i.	24a. WAS AN PERFOR 1 VES 2	MED?	AM CC OF	ERE AUTOPSY FINDINGS RALABLE PRIOR TO OMPLETION OF CAUSE F DEATH?  YES 2 NO
₹	25. WAS CASE REFERRED TO MEDICAL				28.	PLACE OF DEATH (Ch	neck only one	.)			
PHYSICIAN:	EXAMINER?	HOSPITAL: 1 Inpetient 2	ER/Outpatient 3	DOA	OTHER:	Iome 5 🗆 Residence					
黃	27. MANNER OF DEATH	28a. DATE OF I (Month, Day	NJURY	28b. TIM		INJURY AT WORK?			NJURY OCCU	IRED DR	IVER IN
BY	1 Netural 5 Funding 2/ Accident Investigation	3/29/	9 3	12:	3 0 1 1	YES 2XX NO	AUT	0/FIX	ED O	BJEC	- 2 14
	3 Suicide 8 Could not be 4 Homicide detarmined	bullding, a	INJURY — At he	ome, tarm, e	treet, factory, o	ffice	City o	Town, State)	and Number of		
9	29a. CERTIFIER 1 CERTIFYING PHYSI	HIGHWA		92-000C	E-10-E-1		RT,	496			Co., MD.
COMPLET	(Check only one) 2 MEDICAL EXAMINE					lete and place, and due n, death occured at the					nd menner as stated.
BE (	29b. SIGNATURE AND TITLE OF CERTIFIES	116.11				29c. LICENSE NUI			29d. DATE	SIONED (M	onth, Day, Year)
စ္	mugate way	Snuc				O.C.M.	E		03-	30-3	1993
	30. NAME AND ADDRESS OF PERSON WH	h. Ko	Non 1	11 P	enn S	treet, B	alti	more	, Mar	ylar	nd 21201
	APR 06 1993	fula Davido	S SIGNATURE	L							

TO THE HOSEN TO THE FLIMEN De filed within

IDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician.

WISION OF VITAL RECORDS, P.O. BOX 68760,

**BALTIMORE, MARYLAND 21215-0020** 



1993 BINTHPLACE (State or Foreign Country) Pennsylvania

3. TIME OF DEATH A

10d. INSIDE CITY LIMITS? 1 YES 2 NO

14. RACE — American Indian, Black, White, etc.

Approximate Interval Between Onset and Death

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 YES 2 NO

THE

		REGISTRAR		CE	ERTIF	ICATE (	OF DEATH	RE	G. NO.				
	į,	1. DECEDENT'S NAME (First, Middle, Las	st)					2. DATE OF DE	ATH		3. TIME OF DEA		
		Margaret Ma	ry Belsterl	ing				MONTH	DAY	YEAR	12:		
		4. SOCIAL SECURITY NUMBER	5. SEX 6. A	GE (In you pas	t birthday)	IF UNDER 1 YE		7. DATE OF BIR	TH J	93	PLACE (State or		
4944		169-16-9634	1 M 2 X F	72	YRS.	MONTHS DA	YE HOURS MIN.	June 5.		Dom	<sub>ທ</sub> nsvlvan		
houle		Se. SACILITY NAME (If not institution, give	e street and number)			96. CITY, TO	WN OR LOCATION OF D			JACTY OF D			
permit. Pages 1, 2, 3 should	DIRECTOR	St. Joseph's H	ospital			То	wson		I	Balti	nore		
÷,	EC	10a. STATE 10b. COU	NTY	-	10c, CIT	Y, TOWN OR L	OCATION	10d, INSIDE C					
& .:	DIR	MD	Baltimore			Luther	ville						
ermit		10s. STREET AND NUMBER					10f. ZIP CODE		10g. CI	TIZEN OF Y	1 YES 2		
	ER.	301 Felto	n Rd.				21093 USA						
	BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Married 4 Divorced	12. WAS DECEDENT EVI FORCES? 1 1 1 IF YES, GIVE WAR O	YES 24 N	MED	If yes	DECENDENT OF HISPA s, specify Cuban, Mexic YES 2 NO Speci						
r attenuse as	COMPLETED	15. DECEDENT'S E (Specify only highest gri	DUCATION	16a. DE	CEDENT'S	USUAL OCCU	PATION	16b. KIND	OF BUSINESS/IN		1100		
2121 al or atter for use a	<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5+)	life.			g most of working						
AND the hospit detached once.	P P	1.2			Ho	usewif	e	H	lomemake	er			
AND 2121 the hospital or atte detached for use once.	8	17. FATHER'S NAME (First, Middle, Last)					16. MOTHER'S NA	AME (First, Middle,	Maiden Sumame)				
Z > 2 ti	BE	Thomas O'Ne	11.				Su	ızzane G	raves				
MARYLAND  s retained by the hospit  S should be detached notified at once.	5	19a. INFORMANT'S NAME (Type/Print)					reet and Number or Rural			,			
		Beth A. Vellig	an				Rd., Luth	erville	, MD 21	1093			
BALTIMORE, ter death. Page 6 may be the funeral director, page yal.		20a. METHOD OF DISPOSITION 1 Burial 2 ACremation 3 Re	moval from State	cemetery, cre-	matory or o	OF DISPOSITIO			20c. LOCATION -				
MC direct		4 Donation Dother (Specify)  21, SIGNATURE OF PUBLISHAL SERVICE.	week	Metro	Cre	natory	, Inc.	4/3/93	Cator	svil	le, MD		
ALTIMOR death. Page 6 ma tuneral director, p. tuneral director, p. t.		Court	has De	nam	)		mmon-Mitch		defeld.	Inc			
BA er des val.		Lewell M. Leme				10	W. Padoni	a Rd.	Timoniu	m. M			
E 3 % at	7	23. PART I. Enfer the diseases, of heart feiture	r complications that cou	used the de	Mt. Do I	not enter the	mode of dying, suc	ch as cardiec o	r respiratory a	rrest,	Approxir		
- 3 - L T		shock, or heert feliure. List only one cause on each line.  IMMEDIATE CAUSE (Final											
3760, ted within 24 ho completely filled ial, cremation, or event, the m		disease or condition resulting in death)	· INTRA	AVENTRICULAR & SU						2A/	CERU		
760, ed withli ompletel il, crema		Tooling III doubly	DUE TO (OR	AS A CONSEC	DUENCE O	F):	_	1	.0.001	-110	0014		
68760, executed within and completely o burial, cremate well cremate event, matter event,	Z	Sequentially list conditions,	. ITEN	1012	ILH	AG	6						
O. BOX 68 sertificate be execut- ing physician and or griene prior to burit other traumatic	CATION	if any, leading to immediate	DUE TO (OR	AS A CONSEC	OUENCE O	F): ' /	210	01450	110				
BC cate ohysic e price		cause. Enter UNDERLYING CAUSE (Disease or injury	· MEII	72 14	+ 11	<u>C</u>	CATU	CINO	MA	C			
P.O. BOX th certificate be e- ending physician I Hygiene prior to or other traum	CERTIFI	that initiated events resulting in death) LAST	13/1	AS A CONSEC	DUENCE O	+):							
10 10 -	9		d. 1010	011									
CORDS, res that the dea figned by the att medith and Meriting any injury.		PART II. Other significant conditi	ons contributing to dee	th but not n	esuiting	in the under	iying ceuse given in		MAS AN AUTOPSY PERFORMED?	7 24b.	WERE AUTOPSY		
OR in that hed by the any	DICAL								YES 2 NO		COMPLETION OF OF DEATH?		
一一一一	ME										1 YES 2		
						51							
	CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?					6. PLACE OF DEATH (C	heck only one)					
F VIT/ SICIAN: The certificate the State or Item	SICI	1 YES 2 NO	HOSPITAL: 1   Inpetient 2   ER/	Outpatient 3	□ DOA	OTHER:	Home 5 - Residence	8 Other (Spec	ify)				
PHYSICIAN: this certifical with the St.	PHY	27. MANNER OF DEATH	28a. DATE OF INJU (Month, Day, Ye		28b. TIM	E OF 28c	. INJURY AT WORK?	28d. DESCRIBE	HOW INJURY O	CCURED			
ON OD DING PHYS After this death with	ВУ	1 Netural 5 Pending 2 Accident Investigatio					YES 2 NO						
VISION ATTENDING ECTUR: After s after death		3 Suicide 8 Could not t	28e. PLACE OF INJ building, atc. (	IURY — At hor (Specify)	me, farm,	street, factory,	office	281. LOCATION	(Street and Number, State)	er or Rural F	loute Number,		
DIVISION OR ATTENDING I DIRECTOR: After hours after death item 28 is man		4 Homicide determined											
DIV AL OR A L DIREC 2 hours	P	29a. CERTIFIER (Check only	YSICIAN: To the best of my k	nowledge, de	ath occum	ed at the time,	data and place, and du	to the cause(a) a	and manner as st	ated.			
HOSPITAL FUNERAL within 72	COMPLET		NER: On the basis of examin								) and manner as		
HE HO HE FUI ME WILL METAL	ш	296. SIGNATURE AND TITLE OF CERTIF	TIER OLD O				29c. LICENSE NU	MBER ~	29d, DA	TE SIGNED	(Month, Day, Year		
TO THE HOSPIT TO THE FUNERA be filed within 7	0 8	Cloallos	rry				102	588	6	4.	2.0		
	¥	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUSE OF	DEATH (ITER	1 27) (Type	Print)	1 1100	0:70		~			
. (	- 1	CCIKALIDS	MD-S	1	705	C-P+	1 FOH 1	PITAL	, - TC	iuus	IN M		

32. REGISTRAR'S SIGNATURE

hie Devidor Aproporte

place, and due to the cause(a) and manner as stated.

APR - 6 1993

**BALTIMORE, MARYLAND 21215-0020** 

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

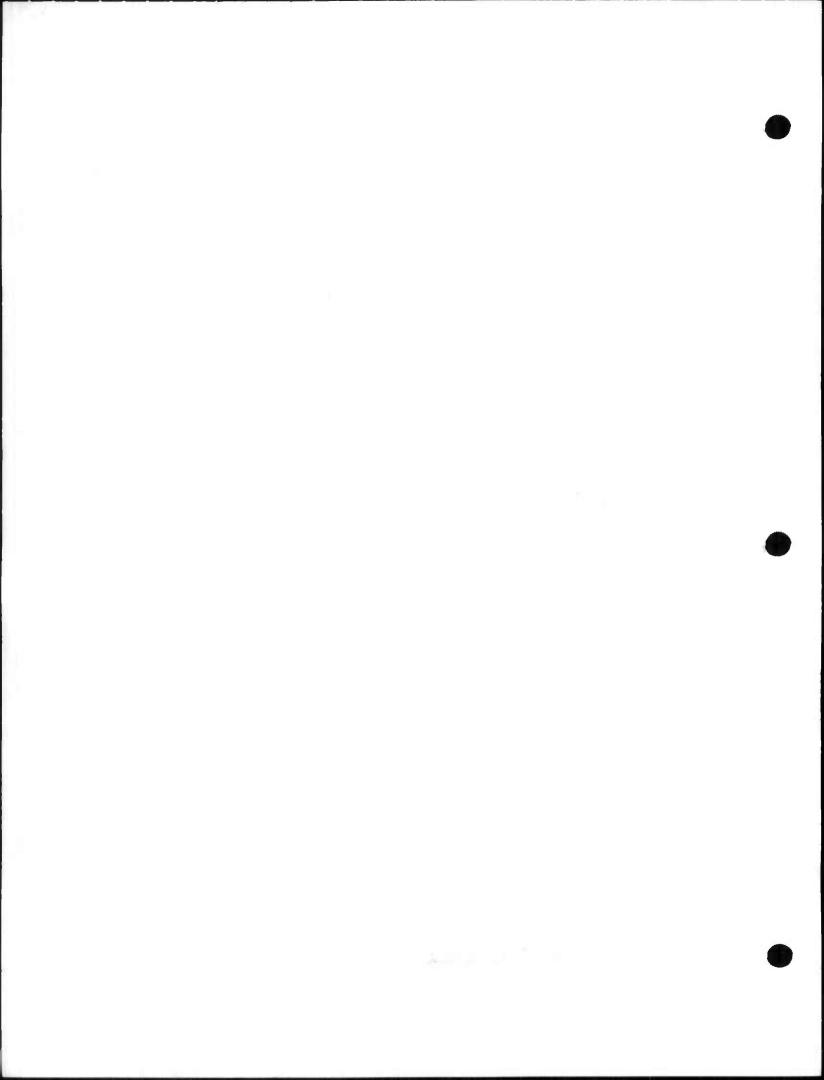
	1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPAI CERTIF	RTMEN	IT OF H	IEALTH AND I	MENTA	L HYGIEN	IE .	0	9576	
	1. DECEDENT'S NAME (First, Middle, Last)	Gardon J.	Craig				2. DATE	E OF DEATH	19		TIME OF DEATH	
6	4. SOCIAL SECURITY NUMBER 353-07-9511	1)( M 2 ( F	E (In yrs. lest birthday) 75 YRS.	IF UNDE MONTHS	DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE (Mon	of BIRTH th. Day, Year) -22-19	17	Country	NCE (State or Foreign	
OR	90. FACILITY NAME (If not institution, give s 3311 Burleith Av				y, town o ltimo	OR LOCATION OF DE	EATH		9c. COUNTY	OF DEAT	Н	
FUNERAL DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE  Md  10b. COUNTY	Y	10c. CIT	ry, TOWN	OR LOCAT	TION	10d. INSIDE CITY V.LIMITS? 1 C YES 2 U NO					
ERAL	100. STREET AND NUMBER 3311 Burleith A			101	ZIP CODE 21215					T COUNTRY?		
B≺	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT, EVER FORCES? 1 \(\int\) YES IF YES, GIVE WAR OR	5 2 NO	13	If yes, sp	ENDENT OF HISPAN ecify Cuben, Mexica 2 NO Specify	n, Puerto	N? (Specify Ye Rican, etc.)	s or No— 14	RACE — Black, W Specify:	American Indian, hite, etc.	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5 +)	18a. DECEDENT'S (Give kind of life. Do NOT u	work done	during mo	DN st of working		Amtrak	SINESS/INDUS	TRY		
BE CON	17. FATHER'S NAME (First, Middle, Last) William Craig					18. MOTHER'S NA Evaler	na		,			
5	190. INFORMANT'S NAME (Type/Print) Eula Craig		3311	Bur	ss (Street a leith	nd Number or Rurel F 1 Avenue	Bal 1	nber, City or Tow timore	, Md 2	1215		
	20e METHOD OF DISPOSITION 1/D/Burlel 2 Cremation 3 Remote 4 Donation 5 Other (Specify)		Db. PLACE AND DATE emetery, crematory or C	OF DISPO	brest	vet	49		Owings			
	21. SIGNATURE OF FUNERAL SERVICE LIC	March			Marc 4300	to ADDRESS OF FAI Ch F/H We D Wabash	est	venue			=	
	23. PART 1. Enter the diseases, or o shock, or heart feliure. IMMEDIATE CAUSE (Final	complications that cause List only ona cause on	ed the death. Do aach line.	not ente	r tha mo	de of dying, suc	h ss car	diac or resp	ratory srrest	9	Approximate interval Between Onset and Daeth	
	disesse or condition resulting in death)	. Motos	A CONSEQUENCE O	lu	neg	Can	ce	7			2 your	
NOI	Sequentially list conditions, if any, leading to immediate	bDUE TO (OR AS	A CONSEDUENCE O		C	<u></u>						
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (DR AS	A CONSEQUENCE O	F):					-			
_ 1	PART II. Other significant condition	s contributing to death	but not resulting	in tha u	nderiving	cause given in	Part i	24a WAS AN	ALITOPSV	245 WE	RE AUTOPSY FINDINGS	
PHYSICIAN: MEDICA								PERFOR	IMED?	AVA COF	ILABLE PRIOR TO MPLETION OF CAUSE DEATH?  YES 2 NO	
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?					ACE OF OEATH (Che	ock only o	ne)				
14SH	1 YES 2 NO 27. MANNER OF OEATH	HOSPITAL:			rsing Home	5 Residence						
ВУ Р	1 R Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	IN.	M		RK? ES 2 ND			NJURY OCCUR			
3 Suicide 8 Could not be determined 28s. PLACE OF INJURY — At home, term, street, fectory, office building, etc. (Specify) 28s. LOCATION (Street and Number or Rural Route Number, City or Town, State)								Number,				
COMPLETED		CIAN: To the best of my knoon.  R: On the basis of examination.								iuse(e) end	d menner ee stated.	
O BE C	296. SIGNATURE AND TITLE OF CERTIFIER  296. LICENSE NUMBER  296. DATE SIGNED (Month, Day, Year)										nth, Day, Year)	

Toch Paven Bluch



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06 1993

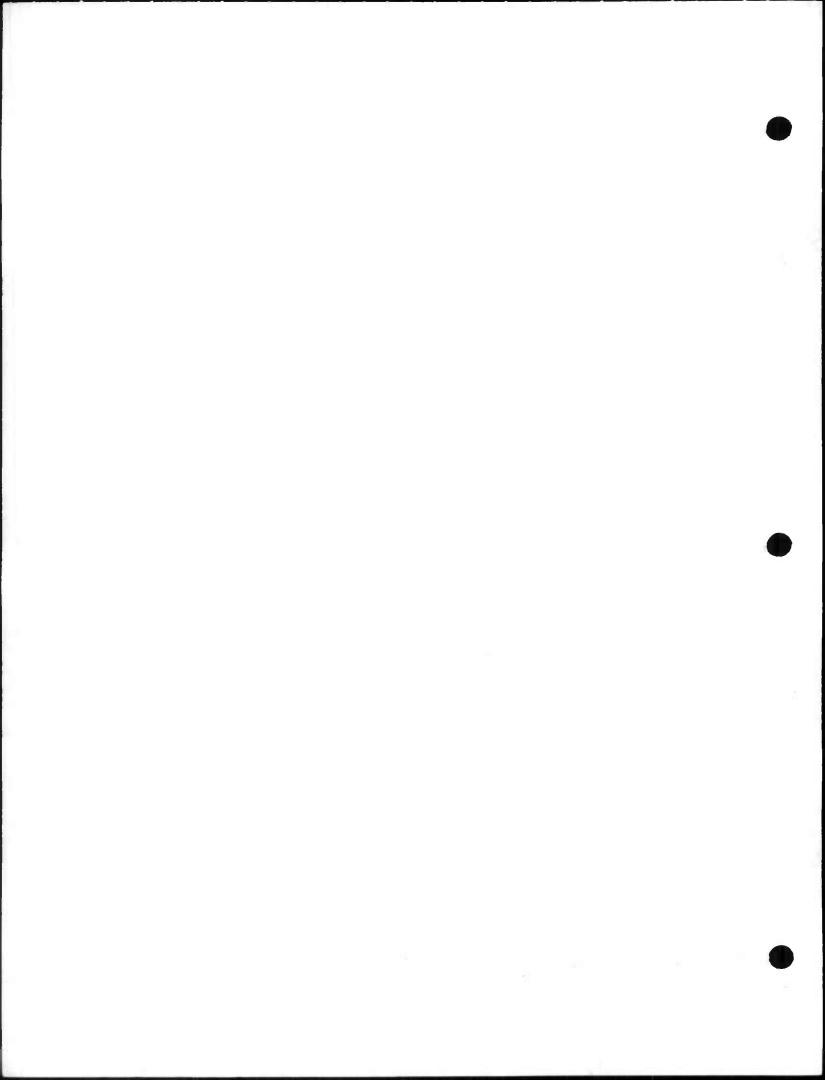


BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

STATE	0F	MARYLAND	<b>DEPARTMENT</b>	0F	HEALTH	AND	MENTAL	HYGIENE
		C	ERTIFICATE	0	F DEAT	TH		REG NO

	1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPART			MENTA	L HYGIEN			
	DECEDENT'S NAME (First, Middle, Last)	Mary Lo	ouise Co	onway		2. DATE	OF DEATH	AV ,	rEAR	3. TIME OF DEATH A
	010 00 1000	5. SEX 6. AGE (III		F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS.	7. DATE	OF BIRTH	1	Countr	PLACE (State or Foreign
OR	90. FACILITY NAME (if not institution, give stre Home, 415 W. 2			b. CITY, TOWN	Baltime			9c. COUNT	Y OF D	
DIRECTOR	RESIDENCE OF DECEDENT  10e. STATE 10b. COUNTY		10c. CITY,	TOWH OR LOCA	TION					10d. INSIDE CITY
	Maryland -  100. STREET AND NUMBER	· <del></del>		10	. ZIP CODE	Bal	timor		N OF W	1 🖾 YES 2 🗌 NO
FUNERAL	415 W. 23rd Str	eet 12. WAS DECEDENT EVER IN U	141.45	21211				USA		
BY	1 Never Merried 2 Merried 3 Wildowed 4 Divorced	J.S. ARMED 2 NO ES						14. RACE — American Indian, Black, White, atc. Specify: White		
COMPLETED		TION Impleted) College (1-4 or 5+)	(Give kind of wor life. Do NOT use i	k done during mo etired.)	ON st of working	168	. KIND OF BU			
OMP	1 1 17. FATHER'S NAME (First, Middle, Last)		Secre	tary	18. MOTHER'S NA	ME (First,			Co	mpany
BE C		re Vicchi			Eqi1	da	Panz	one		
2	19e. INFORMANT'S NAME (Type/Print)				nd Number or Rural					
	COllen Conwa  20e. METHOD OF DISPOSITION 1 & Burlal 2 Cremation 3 Remov.	20b.P	LACE AND DATE OF	DISPOSITION /NE		oat		ltimo cation — ch		, MD21211
	4 Donation 5 Other (Specify)	G	ery, cremetory or othe ardens	of Fa:		4/	Fu	llert	on	, Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICEN	so avoine	tu	Burg   3631	ee-Hens Falls	ss F Roa	unera d Ba	1 Hom	ne	,MD 21211
	23. PART I. Enter the diseases, or col shock, or heart failure. Lie IMMEDIATE CAUSE (Final disease or condition resulting in death)	mplications thát caused to at only one ceuse on acc	in line.		1	ch sa can	disc or respi	ratory arres	t,	Approximate interval Between Onset and Death
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thei initiated events  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):									
	resulting in death) LAST									
PHYSICIAN: MEDICAL	PART II. Other algnificent conditions	contributing to death but	not resulting in	the underlying	g ceuse given in	Part I.	24a. WAS AN PERFOR 1 YES 2	MED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
N.										1 YES 2 NO
CA		HOSPITAL:		26. PL	ACE OF OEATH (Ch	eck only or	10)			
HYS	1 YES 2 NO 1	28e. DATE OF INJURY		☐ Nursing Hom	e 5 Residence		CRISE HOW II			
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUR	Y WO	RK?	200, DE:	CHIBE NOW II	AJORY OCCUP	IED	
	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — building, etc. (Specify)	At home, larm, stre	et, factory, offic			ATION (Street e or Town, State)	nd Number or	Rural R	oute Number,
COMPLETED		AN: To the best of my knowled On the beels of examination e							euse(e)	and menner ee stated.
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER	tay			29c. LICENSE NUI	MBER		29d. DATE S	GNED .	Month, Day, Year)
	30. NAME AND ADDRESS OF PERSON WHO C		1930 Fal		ad Ba	Itin	nore	NAD	7	12.11
	31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S SIGNATION	URE			1111		עיעי	. 4	* * dEm *
- 1	APR - 6 1993	gula varidon-	Moules							



3. TIME OF DEATH

8. BIRTHPLACE (State or Foreign

N.Y.

10d. INSIDE CITY LIMITS?

14. RACE — American Indien, Black, White, etc.

23223

Md.21217

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE

1 YES 2 THO

OF DEATH?

29d. DATE SIGNED (Month, Day, Year)

> 04-01-93

Approximate

Interval Between

Onset and Death

1 TYES 2 NO

9c. COUNTY OF DEATN

10g. CITIZEN OF WHAT COUNTRY?

Brack

USA

5:27A M

2. DATE OF DEATH

04

DAY

01

BALTIMORE, MARYLAND 21215-0020

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

Marionette

4. SOCIAL SECURITY NUMBER

22. S. Greene

31. DATE FILED (Month, Day, Year)
APR 06 1993

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month)

7. DATE OF BIRTH (Month, Day Year) 226 59 -7662 HOURS 1 - M 2 -44 YRS. use as the burial-transit permit. Pages 1. 2. 3 should 9e. FACILITY NAME (If not Institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATN FUNERAL DIRECTOR University Baltimore 10a. STATE 10c. CITY TOWN OR LOCATION Md. Baltimore 10e. STREET AND NUMBER 10f. ZIP CODE 501 N. Brice St. 21223 the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexican, Puerto Rican, atc.)

1 YES 2 NO Specify: 1 Never Married 2 Married BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Education notified at once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Meiden Surname) Joseph Critterton hours after death. Page 6 may be retained by Crystal B. Rogers BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Laverne Thornton 2441 N. 21st St. Richamond, Va. be 20s. METHOD OF DISPOSITION
1 ☐ Burlet ②【 Cremetion 3 ☐ Ramoval from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE musi by the funeral director, removal. "Metro" Crematory 4/5 Balto., Md. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY James. A. Morton & Sons 4 mes 1701 Laurens St. Balto., medical 23. PART //. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, filled in by 1 shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final completely filler the disease or condition Endocarditis executed within resulting in deeth) traumatic event, DUE TO (OR AS A CONSEQUENCE OF): this certificate has been signed by the attending physician and con with the State Dept, of Health and Mental Hygiene prior to burial, with the State Dept, of Health and Mental Hygiene prior to burial, rked, or Item 23 shows any Injury, or other traumatic er Ungal both CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING 2 certificate CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST death PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? insticina Rend that 1 TES 2 NO requires 25. WAS CASE REFERRED TO MEDICAL 28. PLACE QF DEATH (Check only one) HOSPITAL:
1\* Impatient 2 - ER/Outpatient 3 - DOA 1 YES 2 TO OTHER: PHYSICIAN: 4 Nursing Nome 5 Residence 6 Other (Specify) (Month, Day, Year) 27. MANNER OF DEATH 26b. TIME OF 28c. INJURY AT WORK? harked, 28d. DESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending Investiga BY 1 YES 2 NO 2 Accident
3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide datermined 1 X CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(a) and manner as stated. HOSPITAL FUNERAL WITHIN 72 TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT. II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(e) end manner ee stated. 296. SIGNATURE AND TITLE OF CENTIFIES 29c, LICENSE NUMBER D 3 9 3 4 0 BE means 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Bettinson del

Cox

6. AGE (In yrs. last birthday)

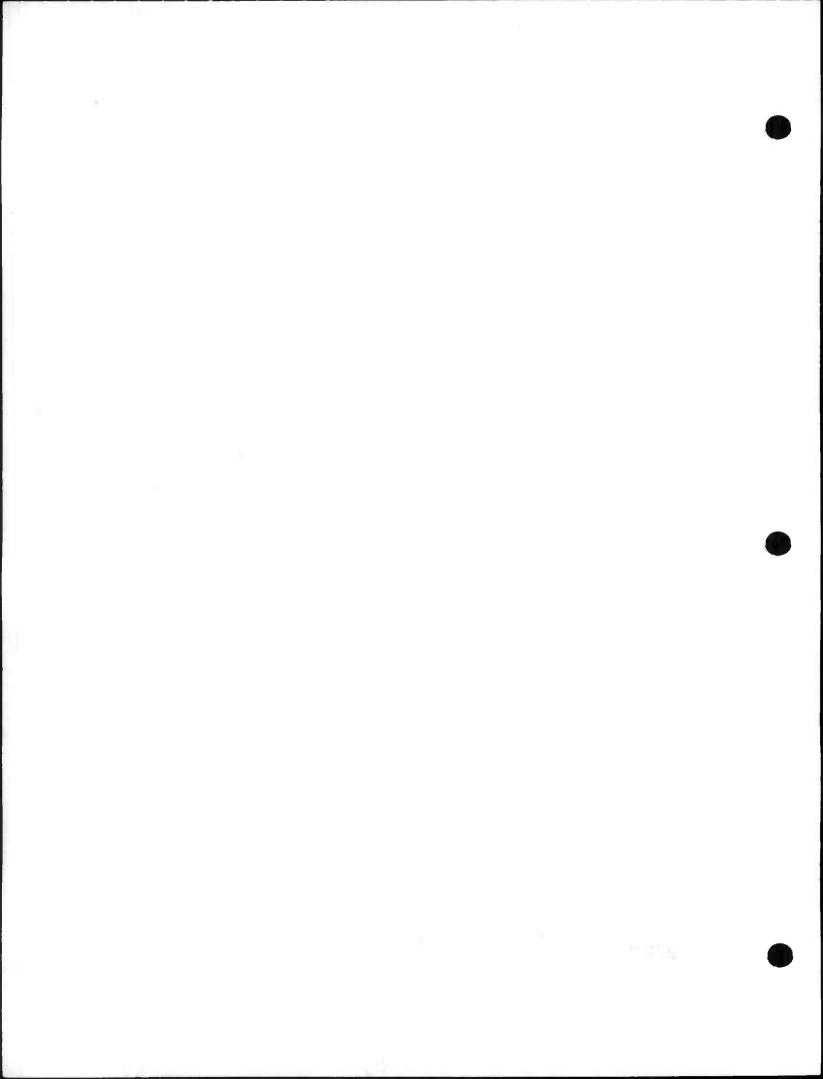
5. SEX

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

IF UNDER 1 YEAR

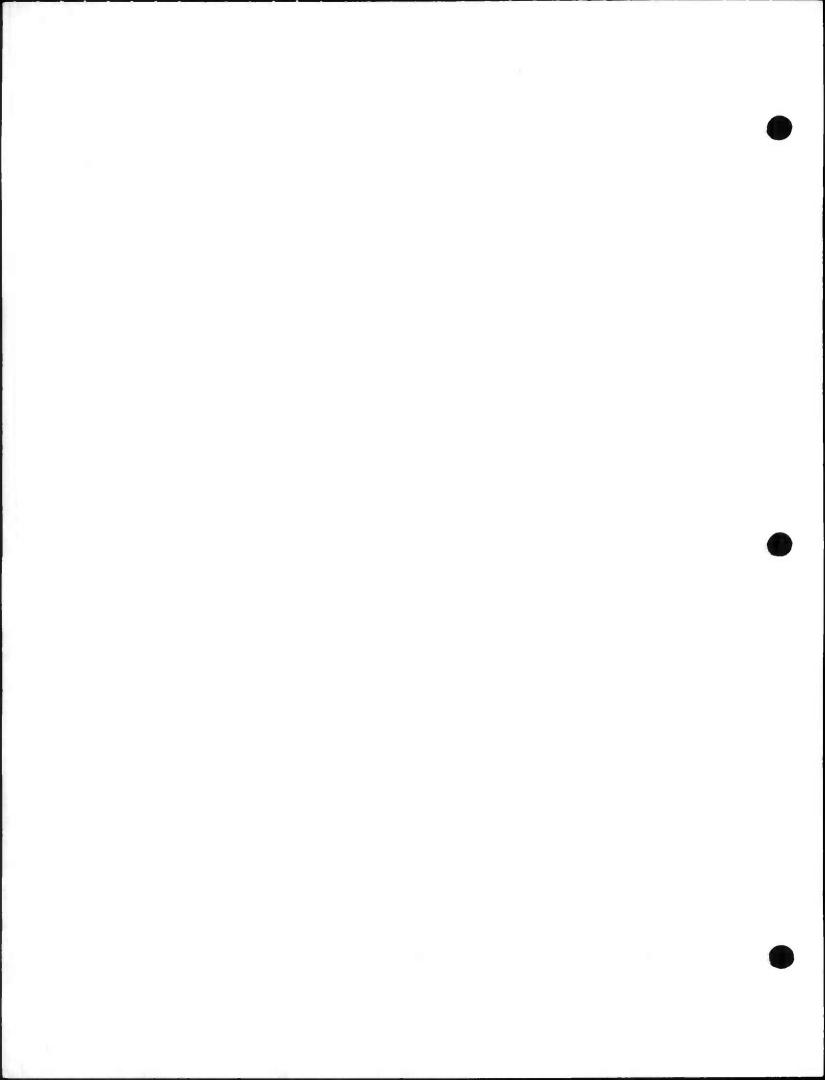
IF UNDER 24 HRS.

DHMH-16 Rev 1/89



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician.
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Itam 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	SIMIE OF MANI	LAND / DEPART	CATE OF	DEATH	MENIAL HYGIE! REG. NO					
	1. DECEDENT'S NAME (First, Middle, Lest)				DEMINI	2. DATE OF DEATH		3. TIME OF	DEATH		
	Vista		COX			04 0	) 1	993	9:41A		
	4. SOCIAL SECURITY NUMBER 5	SEX 6. AG	E (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		8. BIRTHPLACE (Stat	or Foreign		
	246-24-4878	□ M 2 ☐¥F	70 YRS.	AONTHS DAYS	HOURS MIN.	Dec. 22,1	922	NorthCa	rolina		
2	9e. FACILITY NAME (If not institution, give stree Franklin Squa				OSSVIlle			TY OF DEATH			
16	RESIDENCE OF DECEDENT						BAL	TIMORE			
DIRECTOR	Md. BA	ltimore	10c. CITY,	TOWN OR LOCAT	dle Rive	er		10d. INSIDI LIMITS 1 TYES	7		
BY FUNERAL	10e. STREET AND NUMBER			101	ZIP CODE		10g. CITIZ	EN OF WHAT COUNT			
ER	606 Compass Ro	oad		1	212	20		USA			
5	11. MARITAL STATUS 11	2. WAS DECEDENT EVER	IN U.S. ARMED	13. WAS DEC	ENDENT OF HISPAI	NIC ORIGIN? (Specify Ye		14. RACE — America	n Indian,		
Y	1 Never Married 2 Married   FORCES? 1 YES 2 NO   If Yes, specify: Specify:										
	A				A			White	9		
Ë	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use melting.)  16b. KIND OF BUSINESS/INDUSTRY										
iii	Elementary/Secondary (0-12) College (1-4 or 5+) iffe. Do NOT use retired.)										
MP	10th		Hou	sewife							
CO	17. FATHER'S NAME (First, Middle, Lest)  James H. Love	***				ME (First, Middle, Meider					
BE		:cte			Essie	Mae Lovet	te				
0	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DDRESS (Street a	nd Number or Rural	Route Number, City or Tox	vn, State, Zip C	Code)			
-	Margie Evans		1530 1	Meadowc	rest Cou	rt Aberdee	en Md.	21001			
50	204 METHOD OF DISPOSITION 1 Burlel 2 Cremetton 3 Remove	from State	06. PLACE AND DATE OF	DISPOSITION (Na	me of	OATE 20c. LC	CATION - C	Ify or Town, State			
	4 Donation 5 Other (Specify)		emelgrace de l'Asoth	Of Fait	h Cemete	ry 4/5/93	Rossv	ille Md.			
	21. MONATURE OF FUNERAL SERVICE LICEN	SEE	1.1		D ADDRESS OF FA						
	( manalles Fr	100 1 1 0	Ha al	Conne	llyFuner	alHome 300	)MaceA	ve. 2122	L		
	23. PART I. Enter the diseases, or con	oplications that caus	ed the deeth. Do no	t enter the mo	do of dulper aux	h as saedles as sae	lasten. sur	1.000	STREET, STREET		
	anock, or near confide	t only one ceuse on	esch line,	t anter the mo	ue or dying, suc	n sa cardiec or reap	iratory sme		oximate val Between		
	IMMEDIATE CAUSE (Final disesse or condition	ee	1 T C					Onse	t and Desth		
	resulting in death)	Myocardia									
		DUE TO (OH AS	A CONSEQUENCE OF):								
CERTIFICATION	Sequentially list conditions, b	DUE TO (OR AS	A CONSEQUENCE OF):								
AT	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS	A CONSEQUENCE OF J:					i			
윤	CAUSE (Disease or Injury C	DUF TO (OR AS	A CONSEQUENCE OF								
Ē	resulting in desth) LAST	202 10 (011 110	A GONGEOGENOE OF J.								
ш	d	that initiated events  DUE TO (OR AS A CONSEQUENCE OF):  reaulting in death) LAST									
0 1											
ابر	PART II. Other eignificent conditions of	ontributing to deeth	but not resulting in	the underlying	ceuse given in			24b. WERE AUTO	PSY FINDINGS		
ابر	1	ontributing to deeth	but not resulting in	the underlying	j ceuse given in	PERFO	RMED?	AMILABLE I	PRIOR TO		
ابر	PART II. Other significent conditions of Hypertension Cerebrovascular			the underlying	j ceuse given in		RMED?	AMILABLE I COMPLETION OF DEATH?	PRIOR TO N OF CAUSE		
ابر	Hypertension			the underlying	j ceuse given in	PERFO	RMED?	AMILABLE I	PRIOR TO N OF CAUSE		
ابر	llypertension Cerebrovascular 25. WAS CASE REFERRED TO MEDICAL					PERFO	RMED?	AMILABLE I COMPLETION OF DEATH?	PRIOR TO N OF CAUSE		
ابر	Llypertension Cerebrovascular  25. WAS CASE REFERRED TO MEDICAL EXAMINER?	Acciden	t 	26. PL DTHER:	ACE OF GEATH (Ch	PERFO	RMED?	AMILABLE I COMPLETION OF DEATH?	PRIOR TO N OF CAUSE		
ابر	Llypertension Cerebrovascular  25. WAS CASE REFERRED TO MEDICAL EXAMINER?	r Acciden	topatient 3 DOA 4	26. PL OTHER:	ACE OF OEATH (Ch	PERFO 1 YES :	RMED?	AMAILABLE I COMPLETIO OF DEATH? 1 YES	PRIOR TO N OF CAUSE		
PHYSICIAN: MEDICAL	Ilypertension Cerebrovascular  25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO  27. MANNER OF DEATH 1 Notural 5 Pending	Acciden	tpatient 3 DOA 4	26, PL DTHER:   Nursing Home	ACE OF OEATH (Ch	PERFO	RMED?	AMAILABLE I COMPLETIO OF DEATH? 1 YES	PRIOR TO N OF CAUSE		
BY PHYSICIAN: MEDICAL	Iypertension   Cerebrovascular   Cerebrovascul	Acciden	itpetient 3 DOA 4	26. PL  OTHER:  Nursing Hom  Nursing Hom  OF 28c. INJU  WO  1 Y	ACE OF OEATH (Ch	PERFO 1 YES  seck only one) 6 Other (Specify) 28d. DESCRIBE HOW	RMED?  2 NO  INJURY OCCU	AMILABLE COMPLETION OF DEATH?  1 YES	PRIOR TO N OF CAUSE 2 NO		
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E COMPLETED BY PHYSICIAN: MEDICAL	Lypertension   Cerebrovascular	ACCIDENT  OSPITAL: Inpetient 2 = ER/Ou  28a. DATE OF INJUR  Month, Day, Year  28a. PLACE OF INJUR building, etc. (S)	ripatient 3 DOA 4  29b. Time (NJUE)  1Y — At home, farm, streecity)	26. PL DTHER: Nursing Homo Nurs	ACE OF OEATH (Ch	PERFO 1 YES  1 YES  20ther (Specify)  28d. DESCRIBE HOW  281. LOCATION (Street City or Town, State  to the cause(a) and ma  1lime, data and piaca, an	INJURY OCCU	AMILABLE COMPLETION OF DEATH? 1 YES  PRED A Route Number, 1.	PRIOR TO N OF CAUSE Description NO NO NO NO NO NO NO NO NO NO NO NO NO		
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

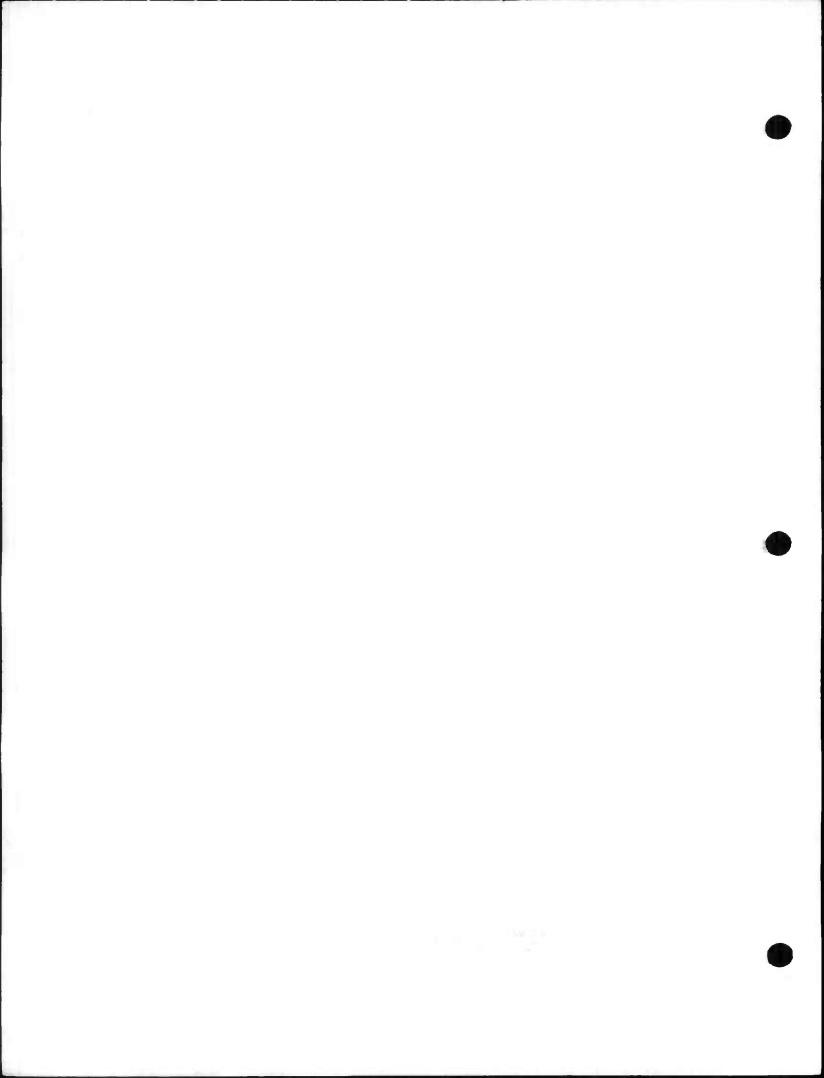
BALTIMORE, MARYLAND 21215-0020

The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

_		FOR STATE REGISTRAR	STATE OF MARYLAND / DEPART CERTIFIC	MENT OF HEALTH AND I	MENTAL HYGIENE REG. NO.	0 3 3 0 0
		1. DECEDENT'S NAME (First, Middle, Lest)	Dalvis		2. DATE OF DEATH MONTH DAY YEA	3. TIME OF DEATH PM
D	į.	4. SOCIAL SECURITY NUMBER 2/6-09-6146		IF UNDER 1 YEAR IF UNDER 24 HRS, NONTHS DAYS HOURS MHN.	7. DATE OF BIRTH 8. BI	RTHPLACE (State or Foreign M
2. 3 should	TOR	9a. FACILITY NAME (If not institution, give st	Edicare Center	96. CITY, TOWN OR LOCATION OF DE	ATH 9c. COUNTY O	F DEATH
it. Pages 1.	DIRECTOR	10a. STATE 10b. COUNTY	10c. CITY,	TOWN OR LOCATION		10d. INSIDE CITY LIMPTS? 1 PYES 2 NO
nsit perm	FUNERAL	15 30 Cross	Country Blud	101. ZIP CODE 2/2 C		OF WHAT COUNTRY?
the burial-transit permit. Pages 1,	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Diversed	12. WAS DECEDENT EVER IN U.S. ARMEST FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPAN If you, specify Cultum, Mexican I VER 2 NO Specify	IIC ORIGIN? (Specify Yes or No.— 14, R n, Puerto Rican, etc.)	ACE — American Indian, liack, White, atc.
for use as	LETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)		rk done during most of working	166. KIND OF BUSINESS/INDUSTR	
e detached t once.	COMPI	EZ FATHER'S NAME (FIRE ARISIN, LASE)	,	IS. MOTHER'S NA	ME (First, Missin, Maisin Surrylmu)	non
5 should be notified at	TO BE	18. FORMANT'S NAME (HOWFIN)	18b. MAILING.A	DODESS (Street and Number or Number	South Number City or Spen, State, Zip Code	121201
ector, page	1	28s. V=7HOO OF DISPOSITION  1 In Burial 2 Cremetion 3 Remo 4 Donetion 5 Other (Specify)	oval from State  On PLACE AND DATE OF Cemetery, cranilogy or state	DISPOSITION (Name pl	DATE 20c. LOCATION City o	r Town, State
e funeral die examiner		2 SUBSHINGS OF FUNERAL SERVICE LO	College	22. NAME AND ADDRESS OF FAC	chirt Willace Franklei Street	5
spletely filled in by the cremation, or remove rent, the medical		23. PART I. Enter the diseasea, or canonic state of the control of	omplications that caused the death. Do no list only one cause on each line.  DUE.TO (OR AS A CONSEQUENCE OF):	Shock	h as cardiac or respiratory arrest,	Approximate interval Between Onset and Death
the attending physician and completely filled in by the funeral director, page 5 should be detached Mental Hygiene prior to burial, cremation, or removal. Injury, or other traumatic event, the medical examiner must be notified at once.	ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):	genic sh	Jopaty	
y the atternd Mental	AL C	PART II. Other eignificant condition	Contributing to death but not resulting in	the underlying cause given in	Part I. 24s. WAS AN AUTOPSY PERFORMED?	24h. WERE AUTOPSY PINDINGS AMALAGLE PRIOR TO
9 3	: MEDIC	CH F(G	uses tive los	ext faulu	10 YES 20 NO	COMPLETION OF GAUSE OF DEATH? 1 YES 2 20 NO
ficate has t State Dept r Item 23	SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO		26. PLACE OF DEATH (Che OTHER:		
fter this certifeath with the marked, or	ВУ РНУ	27. MANNER OF DEATH  Natural 5 Pending  Accident Investigation	28a. DATE OF INJURY (Morith, Day, Year) 28b. TIME INJUR	OF 28c. INJURY AT	28d. DESCRIBE HOW INJURY OCCURED	
after d	ETED E	3 Suicide 6 Could not be determined	26e. PLACE OF INJURY — At home, farm, str building, etc. (Specify)	set, factory, office	281. LOCATION (Street and Number or Rui City or Town, State)	ral Route Number,
3 R =	COMPL		CIAN: To the best of my knowledge, death occurred R: On the basis of examination and/or investigation,			se(e) and manner se stated.
fled w	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER	NMAD	29c. LICENSE NUM	29d. DATE SIGN	NED (Month, Day, Year)
		30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH (ITEM 27) (Type, P	1 MC LI	best high	BultHo
		ADD 06 1993	relia Beirden Bondalle		. 0	

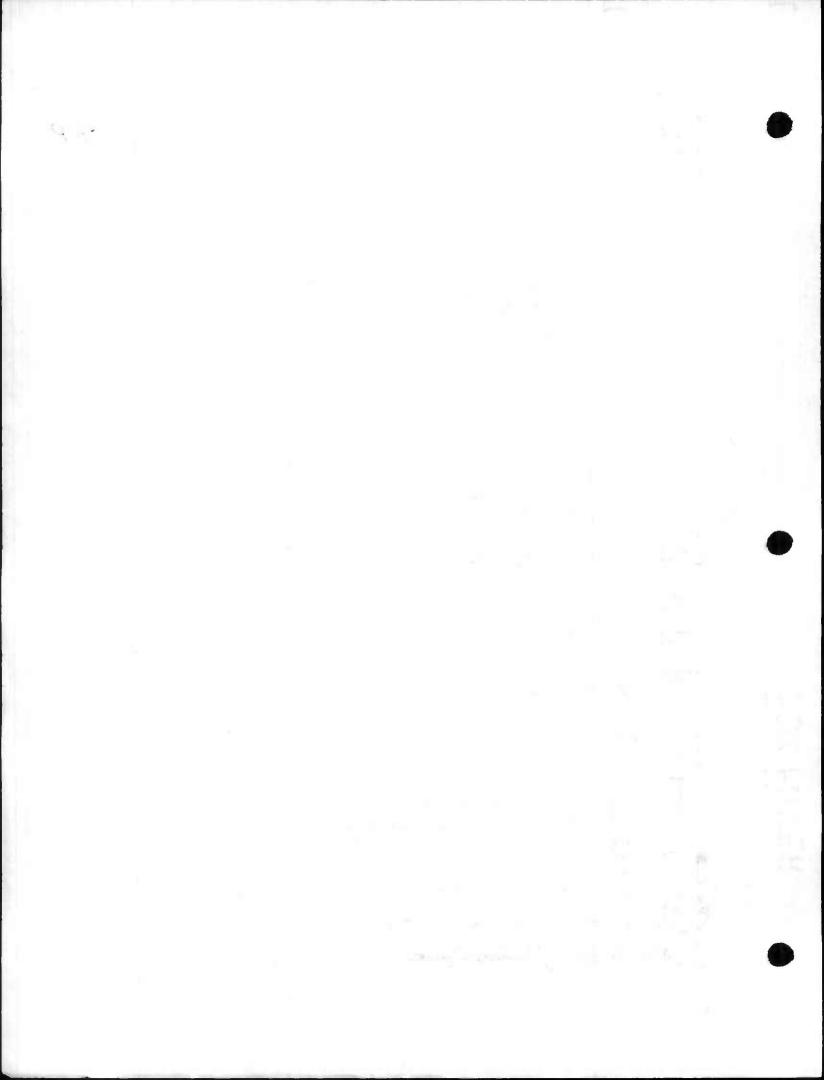
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	ASP 4/26/93 t. 1 - STATE REGISTRAR	tstate of a	MARYLAND	/ DEPAR	RTMENT O	F HE	ALTH	AND	MENTA	AL HYGIEI	NE		
	1. DECEOENT'S NAME (First, Middle, Last)			LRIN	TOMIL	01 1	DEA	I II		REG. NO	). 		3. TIME OF DEATH
	MARQUEZ		G.		DUT	тОТ	N		0 4	01	19	93	6:21 A M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. Is	ast birthday)	IF UNDER 1 Y	EAR	IF UNDER	1	7. DATE	OF BIRTH		S. BIRTI	IPLACE (State or Foreign
	N/A	1 💢 M 2 🗌 F		YRS.	MONTHS D	AYS	HOURS	MIN.	(Mon	th, Day, Year)	003	Count	md
	9a. FACILITY NAME (If not institution, give st	ireet and number)			9b. CITY, TO	WN OR	LOCATI	ON OF D	EATH			NTY OF E	1.144
DIRECTOR	SINAI HOSPITA	AL .			BALT	IMO	ORE						
EC	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN OR L	OCATIO	N.						10d, INSIDE CITY
DIR	Md				timore								LIMITS?
	10e. STREET AND NUMBER				* *********		ZIP COD	E			10g. CIT	IZEN OF	WHAT COUNTRY?
FUNERAL	2621 W. Coldspri	ng Lane				21	1215	j			1 -	SA	
12	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. A	RMEO	13. WAS	DECE	NDENT C	OF HISPAI	VIC ORIGI	N? (Specify Ye	s or No-	14. RACI	- American Indian,
BY F	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE W		INO				in, Maxica Specif		Rican, atc.)			k, white, etc.
	15. OECEDENT'S EDUC	CATION	16a D		USUAL OCCU	31710N	^	_	T 40				DIACK
	(Specify only highest grade Elementary/Secondary (0-12)	completed)			work done durin			ng	16	b. KIND OF BL	JSINESS/IN	DUSTRY	
립	Elemental y decordary (0-12)	College (1-4 or 5+	''										
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTI	HER'S NA	ME (First,	Middle, Maide	Surname)		
BE 0	Gaylord Dutto	n								ogers			
2	19a. INFORMANT'S NAME (Type/Print)	JAN 19 E. T	11	96. MAILING	ADDRESS (St	reet and	Number	or Rumil	Route Nun	ober, City or Tox	vn, State, Zip	Code)	
-	Evelyn Rogers				7	- 2	2621	W.	Cold	dsprip	g lan	е Ва	Itimore, Md
	20e, METHOD OF DISPOSITION  1	oval from State	20b. PLACE	ANODATE O	OF DISPOSITIO	N (Nam	e of		DA	TE 20c. L.	OCATION -	Cify or To	wn, Stata
	4 Donation 6 Other (Specify)	ENORG	King	Memo	rial P	_	_			3 Rand	dalls	town	, Md
	21. SIGNATURE OF PUTERAL SERVICE LIC	ENSEE	/					SS OF FA					
	Torus &	won			43	00	Wab.	ash	Aver	lue			
	23. PART I. Enter the diseeses, or c shock, or heart fellure. I	omplications that	caused the d	eath. Do r	not enter the	mode	of dyl	lng, suc	h as cer	diac or resp	iratory an	rest,	Approximate interval Between
	IMMEDIATE CAUSE (Final												Onset and Death
	resulting in death)	COMPLI	CATION	VS OF	PREI	MAT	URI	[ T Y					
_	_	DUE TO	(OR AS A CONSE	EOUENCE OI	F):								
CERTIFICATION	Sequentially list conditions, if any, leading to immediate		OR AS A CONSE	OUENCE OI	F):			_					
S	cause. Enter UNDERLYING CAUSE (Disease or injury												!
E	that initiated events	OUE TO	(OR AS A CONSE	OUENCE OF	F):								
照	resulting in death) LAST	ı											
<u></u>	PART II. Other aignificant conditions	s contributing to	death but not	reaulting I	In the under	lying (	ceuse g	jiven in	Part I.	24a. WAS AF	AUTOPSY	24b	WERE AUTOPSY FINDINGS
MEDICA										PERFO			AVAILABLE PRIOR TO COMPLETION OF CAUSE
ij.										1,23			OF DEATH?
													/A 120 2 🗆 110
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL				6. PLAC	CE OF D	EATH (Ch	eck only o	ne)			
XS.	1 YES 2 □ NO	HOSPITAL: 1 Inpetient 2	ER/Outpatiant	3 DOA	OTHER:	Home	5 🗆 Re	sidence	6 🗆 Oth	er (Specify)			
표	27. MANNER OF DEATH	28a. DATE OF (Month, Da		26b. TIMI	E OF 28c	. INJUR	RY AT		28d. DE	SCRIBE HOW	INJURY OC	CUREO	
B⊀	1   Accident   5   Pending   Investigation			121			S 2 [	NO					
	3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE Of building,	F INJURY — At he arts. (Specify)	ome, farm, s	Rreet, factory,	offica			281. LOC City	OATION (Street or Town, State	and Number	or Rural F	loute Number,
	an armina												
COMPLETED	(Check only												
00	2 MEDICAL EXAMINER		amination and/or	investigatio	n, in my opinio	on, dea	th occun	ed at the	time, date	and place, a	nd dua to th	e cause(s	) and manner as stated.
8	29b. SIGNATURE AND TITLE OF CERTIFIER	1111.	1/1 11	^		2		NSE NUM					(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO	UNIA.	M-INI	2_			0.0	С.М.	. E		▶ 04	4 – 0 1	1993
					-	+~~	A +	D.	1+:	more	Ma	pr. 1 -	nd 21201
	DONALD G. WRIGH  31. DATE FILED (Month, Day, Year)				SIIII S	CTE	CL,	, Do	11 L L	люте,	, Mal	гутс	ind 21201
	APR 06 1993	have Davids	R'S SINTURE										



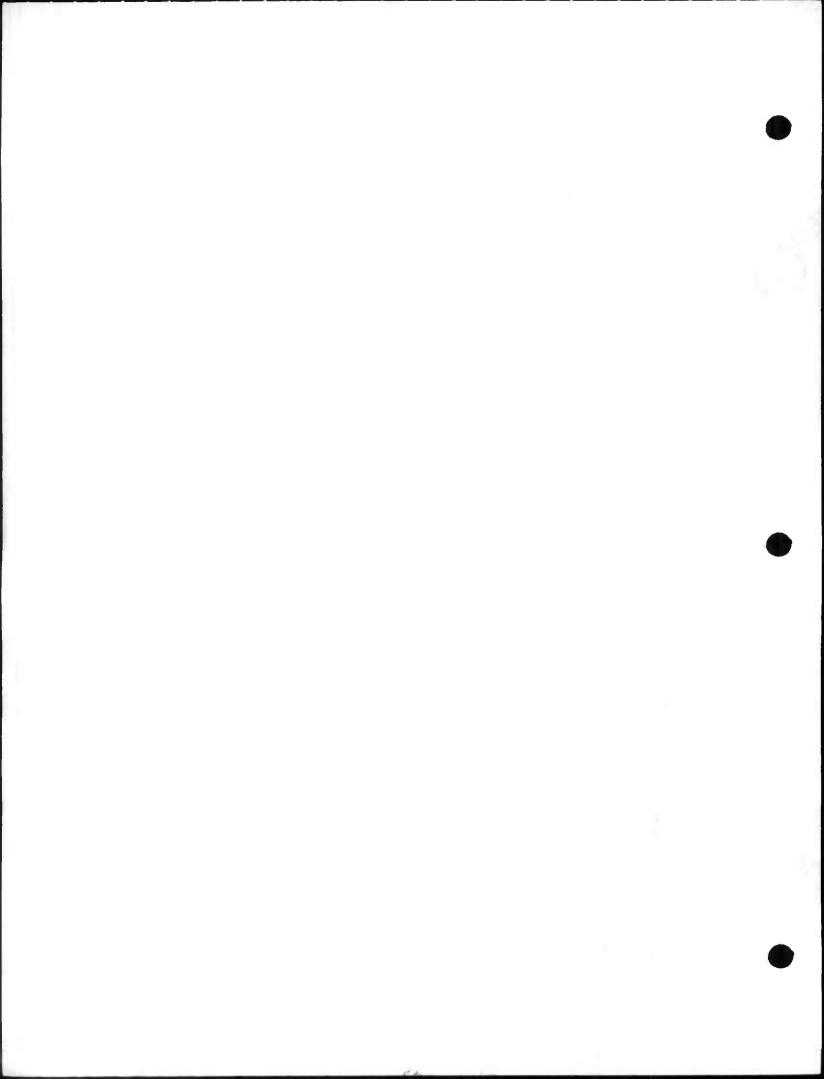
COUNTY, THE DATE OF THE PARTY O	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	ith the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	d, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
O THE MOST INC. OF ALL LANDING THE PARTY OF	O THE FUNERAL DIRECTOR: After this certificate has been signed by the	e filed within 72 hours after death with the State Dept, of Health and W	MPORTANT: If item 28 is marked, or item 23 shows any inj

FOR 1 - STATE REGISTRAR	STATE OF MARY	LAND / DEPARTI			MENTAL	HYGIEN REG. NO.	E	33 0338
1. OECEDENT'S NAME (First, Middle, Last, HELEN LOU		FORD			2. DATE MONTH		1993	S. TIME OF DEATH
4. SOCIAL SECURITY NUMBER 218-09-8020D		(In yrs. last birthday)	F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE (	OF BIRTH (, Day, Year) 22 190	6.	BIRTHPLACE (State or Foreign Country)  1ARYLAND
99. FACILITY NAME (If not institution, give HAMMONDS LANE NU			BROOKLY	N PARK			9c. COUNTY	ARUNDEL
RESIDENCE OF DECEDENT  100. STATE 10b. COUN  MARYLAND ANNE	TY E ARUNDEL	10c. CITY,	TOWN OR LOCA	TION				10d. INSIDE CITY LIMITS? 1  YES 2 X NO
100. STREET AND NUMBER MERIDIAN NURSING		BROC		1. ZIP CODE			U.S.	N OF WHAT COUNTRY?
11. MARITAL STATUS  1 □ Never Merried 2 □ Merried  3 ☑ Widowed 4 □ Divorced	12. WAS DECEDENT EVER FORCES? 1 YES, GIVE WAR OR	S 2 NO	If yes, s	CENDENT OF HISPAI Decify Cuban, Mexico 3 2 XNO Specific	en, Puerto F			. RACE — American Indian, Black, White, etc. Specify: WHITE
15. OECEOENT'S EO (Specify only highest grad Elementary/Secondary (0-12)		16a. DECEDENT'S US (Give kind of wor	k done during m		16b.	KIND OF BU	SINESS/INDUS	STRY
12  17. FATHER'S NAME (First, Middle, Last)	NONE	HOME	1AKER	16. MOTHER'S NA		N HOM		
WILLIAM	FRICK			AUGUS	TA		DANHA	
19a. INFORMANT'S NAME (Type/Print) HELEN M. WOOTTEO	)N			ROSS RD.				21090
20a. METHOD OF DISPOSITION  1 N Burlel 2 Cremation 3 Ra 4 Donetion 6 Other (Specify)	moval from State	PLACE AND DATE OF COMMENTS OF	F DISPOSITION other place)	(Name	OAT	20c. LO	CATION CI	ty or Town, State
21. SIGNATURE OF FUNERAL SERVICE L		le L	22. NAME A SINGL	ETON FUN	ERAL	HOME		IE, MD 21061
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	b. DUE TO (OR AS	A CONSEQUENCE OF):  A CONSEQUENCE OF):		C Bls				
PART II. Other significant condition		but not resulting In	the underlying	ng cause given in	Part I.	24a. WAS AN PERFOI 1 YES	RMED?	24b. WERE AUTOPSY FINDIN AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?  1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				PLACE OF DEATH (C	heck only or	10)		
1 YES 2 NO	HOSPITAL: 1 Inputient 2 ER/O	utpatient 3 DOA		me 5 Residence			INJURY OCCU	DED.
1 Natural 5 Pending Investigation	(Month, Day, Year	) INJU	M 1 🗆	ORK? YES 2 NO				
3 Suicide 6 Could not b 4 Homicide determined	building, atc. (S)	RY — At home, farm, at pecify)	eet, fectory, offi	ce	28f. LOC City	ATION (Street or Town, State	and Number of	r Rural Route Number,
Contract only	SICIAN: To the best of my known NER: On the beels of examine							
(Check only 2 MEDICAL EXAM) 29b. SIGNATURE AND TITLE OF CERTIF	NER: On the beefs of exeminer	tion end/or investigation	in my opinion,		e time, date		nd due to the	couse(e) end manner ee stated. SIGNED (Month, Day, Year)
(Check only one) 2 MEDICAL EXAMI	NER: On the beefs of exeminer	tion end/or investigation	in my opinion,	death occured at the	e time, date		nd due to the	ceuse(e) end manner ee stated.



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N OF VITAL RE	PHYSICIAN:
VISIO	ATTENDING
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	- STATE REGISTRAR		CE	RTIF	ICATE O			B:	EG. NO.	_		
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF D	DEATH			3. TIME OF DEATH
1	PHILI						APRIL 4,1993		YEAR	1:45 A M		
	4. SOCIAL SECURITY NUMBER	6. AGE (In yrs. last	t birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.			7. DATE OF BIRTH		.993	a BIRTI	IPLACE (State or Foreign		
	213-30-6161	YRS.	MONTHS DAYS	HOURS	MIN.	(Month, Day	( Year)	.00	Countr	7/)		
	90, FACILITY NAME (If not institution, give st	M 2 F	83	-	9b. CITY, TOWN	OR LOCATION		JUNE 6	, 19	_	POL	AND
~					-		N OF DE	AIN				
5	CITIZENS NURSING	HOME			FREDE	RICK				FRE	DERI	CK
ñ	10e. STATE 10b. COUNTY			10c. CIT	Y, TOWN OR LOC	ATION						10d. INSIDE CITY
DIRECTOR	MARYT.AND			BA.	LTIMORE							LIMITS?
4	10e. STREET AND NUMBER					of, ZIP CODE				10a CIT	TZEN OF Y	WHAT COUNTRY?
3	4393 CRESTHEIGHTS	C DD								log. on		
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT	FVED IN II S AD	MED	12 WAS DE	212		C ORIGIN? (Sp	-14 . 14		US	
	1 Never Married 2 Merried	FORCES? 1	YES 2 N	10	If yes, i	pecify Cuben,	Mexican	, Puerto Rican	, etc.)	or No-		— American Indian, k, White, etc.
ВУ	3 X Widowed 4 Divorced	IF YES, GIVE W	AR ON DATES		1 U YE	S 2 NO	Specify:				Speci	
입	15. DECEDENT'S EDUC	ATION	16a. DE	CEDENT'S	USUAL OCCUPAT	ION		16b. KINI	OF BUS	INESS/INI	DUSTRY	WHITE
<u> </u>	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	Silva	ve kind of Do NOT u	work done during ri se retired.)	nost of working						
립	6	00.000		AKER				DAI	DICE	DIC	וכו א כו	מע
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			ALCUIT		18. MOTNE	R'S NAM	E (First, Middle			BAKE	RY
	HENRY LOUIS I	FOX				SARA			NOWN			
BE	19e. INFORMANT'S NAME (Type/Print)		196	. MAILING	ADDRESS (Street						n Codel	
2	100 0000000	DITOMAN										21760)
1	MDS FDANCES FOY-		6500 MORNINGSIDE CT. MIDDLE 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 200							C. LOCATION — City or Town, State		
	1 X Buriel 2 Cremetion 3 Remo	wal from State			ZION CE		4.	5-93				- 41.500
- 1	21. BIGNATURE OF FUNERAL PERVICE LICE	ENSEE ()	DILAA	KEI		ND ADDRESS	-	~ / \	ROS	EDAL	E, M	υ.
	· Mrs.	111 17	<i>F</i>	*	1			& BRO	2			
_	MAKK	1/1/	Unil	n	601	RETS	TERS	I MWOTE	RD.	BALT	0., 1	MD.(21215)
	23. PART I. Enter the diseases of each ahock, or heart tenure. L	omplications that	caused the dea	ath. Do i	not enter the m	ode of dyln	g, auch	ss cardiac	or respli	ratory an	reat,	Approximata
	IMMEDIATE CAUSE (Final	and only one odd.	out the state of t									Interval Between Onset and Death
{	disease or condition resulting in desth) a. Dieumon a. 5 days											
1	OUE TO (OR AS A CONSEQUENCE OF):											
Z	Sequentially list conditions b	A/21	heime	(15	dised	rse	,					10 4RS
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (	OR AS A CONSEC	DUENCE O	F):							0
2	CAUSE (Disease or injury											
₽ I	that initiated events resulting in death) LAST	DUE TO (	OR AS A CONSEO	UENCE O	F):							
E	de de la contraction de la con											
	PART II. Other aignificant conditions	contributing to	death but not re	esulting	In the underlying	na cause als	ven in F	Part I 24a	WAS AN	Almoney	1 246	WERE AUTOPSY FINDINGS
DICAL	Cancer of b1					ig oddoc gir			PERFOR		240.	AWAILABLE PRIOR TO
								_ 10	YES 2	NO		OF DEATH?
: ME	Parkinson's	asseas	<u>e</u>					_				1 TYES 2 NO
Ž												
PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER:	LACE OF OEA	ATH (Chec	ck only one)				
ΥS	1 YES 2 NO	1   Inpetient 2		□ DOA		me 5 🗆 Resi	dence 8	Other (Spe	iclfy)			
표	27. MANNER OF DEATN  1 Netural 5 Pending	28s. DATE OF I (Month, De		28b. TIM		JURY AT ORK?		28d. DESCRIB	E NOW IN	JURY OC	CUREO	
B	2 Accident Investigation					YES 2 🗌	NO					
	3 Suicide 8 Could not be 4 Nomicide determined	28e. PLACE OF building, a	INJURY — At hor tc. (Specify)	ne, farm, :	street, factory, offi	Ce		28f. LOCATION City or Tow	(Street au	nd Number	or Rural A	loute Number,
	Nomicide determined											
4	(Check only 1 CERTIFYING PHYSIC	IAN: To the best of r	ny knowledge, des	ith occurr	ed at the time, dat	e end place, e	nd due t	o the cause(e)	end man	ner as atai	led,	
COMPLETED	one) 2 MEDICAL EXAMINER											) end menner ee stated,
	29b. SIGNATURE AND TITLE OF CERTIFIER					29c. LICEN			-			(Month, Day, Year)
8	mich 11 1.	· lane -	m			7/-	1 1	/		≥ d	2 aluneu	MUNIT, Day, 1987)
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETEO CALISI	OF DEATH (ITEM	27) /June	Print)	011	60	/	البيي	- 6	epic	(4, 1993
	HARP MEDICAL	1-1					7	7				1
ŀ	31. DATE FILED (Month, Day, Year)	32. REGISTRAR		Tori	n M.	U 2/	16	1				
1	APR - 6 1993	Julia Day	iden Jan	LE								



	FOR
1	STATE
E	REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCITAL

	1 - STATE REGISTRAR	CI			F DEATH	REG. NO			
1	1. DECEDENT'S NAME (First, Middle, Last)	Foldst	pin			2. DATE OF DEATH		3. TIME OF DEATH	
	1 - 1 - 1 - 1 - N	SEX 8. AGE (In yrs. las	st birthday)	IF UNDER 1 YEAR		7. DATE OF BIRTH (Month, Day, Year)	8.	BIRTHPLACE (State or Foreign Country)	
	011111	M2□F X	YRS.	MONTHS DAY	HOURS MIN.	5/10/05		ARYLAND	
L	9a. FACILITY NAME (If not institution, give stree	TOL		A	N OR LOCATION OF D		9c. COUNTY	OF DEATH	
18	RESIDENCE OF DECEDENT	1111		1897(	IMORE,	WI U	1	, , , , , , , , , , , , , , , , , , , ,	
DIRECTOR	10e. STATE 10b. COUNTY		10c. CIT	, TOWN OR LO	CATION			10d. IHSIDE CITY	
	MARYLAND		BAL	TIMORE				1 VES 2 NO	
RAI	10e. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?	
FUNERAL	6302 FAIRLANE DR.	2. WAS DECEDENT EVER IH U.S. AR	MED	12 144 6 7	21209	NIC ORIGIN? (Specify Ye	USA	RACE American Indian.	
	1 Never Married 2 X Married	FORCES? 1 YES 2 XI		If yes,		an, Puerto Rican, etc.)	# OF NO 14.	Black, White, etc.	
D BY	3 Widowed 4 Divorced							SpecifWHITE	
	15. DECEDENT'S EDUCAT (Specify only highest grade cor	npleted) (G	CEDENT'S live kind of w Do NOT us	USUAL OCCUPA rork done during	TION most of working	18b. KIND OF BU	SINESS/INDUS	TRY	
12	Elementary/Secondary (0-12)	Jonege (1-4 or 5 +)							
ONCE. COMPLETED	17. FATHER'S HAME (First, Middle, Lest)		ERCHA	INT.	18. MOTHER'S HA	AME (First, Middle, Maiden	Surname)		
M M	JOSEPH	FELDSTEIN			IDA	RO	SENBLA	rr	
TO B	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Tow			
90	RONALD FELDSTEII 204, METHOD OF DISPOSITION				PL. BELTS		20705		
Hust	1 Donation 5 Other (Specify)	I from State 20b. PLACE / cemetery, cre SHAZ	and DATE C	her plece			CATION — City		
	21. SIGNATURE OF CONERAL SERVICE LICEN		TULL .	7	AND ADDRESS OF FA		OSEDALI	E, MD.	
CAGIIIII	SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTO., MD. (21215)								
	23. PART I. Effer the diseases, of con-	plications that caused the de	ath. Do n	ot antar tha r	node of dying, suc	SRSTOWN RD	BALTO Arrest	O., MD. (21215) Approximata	
	shock, or heart teffure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  a. Ropus Tay Solww								
degill,	Sequentially list conditions, if any, laading to immediate Course Enter INDERLY WAG.								
ATION	Sequentially list conditions, b.	OHE TO YOU AS A COURSE	JE TO (OR AS A COHSEQUENCE OF):					st.	
AT	If any, laading to immediata cause. Enter UNDERLYING	Sensis-	OUENCE OF	,	0		U		
TFK	CAUSE (Disease or injury that initiated events	DUE TO (OF AS A CONSEC	DUENCE OF	):					
5   155	resulting in death) LAST								
5 4 1	PART II. Other significant conditions of			n tha undarly	Ing cause given in	Part I. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS	
	S/o MJ, Hypoth	ymidiam,	NED	M;	Chris	PERFOR		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
: ME	1 april ; C	8 PD, 90	nt				/\	1 TES 2 NO	
Ä		0						<u></u>	
PHYSICIAN		OSPITAL:		OTHER:	PLACE OF DEATH (C/				
HYS	27. MAHNER OF DEATH	Inpetient 2 ER/Outpetient 3  28e. DATE OF INJURY	28b. TIME		Dime 5 Residence	8 Other (Specify)  28d. DESCRIBE HOW I	N HIEV OCCUP	en	
	150 Natural 5 Pending	(Month, Day, Year)	INJ	JRY	VORK?	200. DESCRIBE HOW I	INJUNI OCCUM	EU	
	2 Accident Investigation 3 Suicide 6 Could not be	28a. PLACE OF IHJURY — At ho- building, atc. (Specify)	ma, farm, s	treet, factory, of	fica	281. LOCATION (Street		Rural Route Number,	
ETED	4 Homicide determined	(Spoonly)				City or Town, State)			
릴		H: To the best of my knowledge, de On the besis of examination and/or I						suse(s) and manner as atmed.	
O BE CON	296. SIGNATURE AND TUILE OF CERTIFIER	O 11		0.0	29c. LICEHSE HU	MBER	29d, DATE SI	GNED (Month, Pay, Year)	
TO B	MATRIC	TE HOUSE	STA	TF			D 4	13/93	
-	30. NAME AND ADDRESS OF PERSON WHO C	A	M 27) (Type,	1000				/ /	
	31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SAGHATURE	ISA	4141	TORE				
	Committee of the control of the cont	TE TIEST THE S STORE UNIT			,				

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

APR 6 1993 Juli Switzer Proces

OHMH-16 Rev 1/89

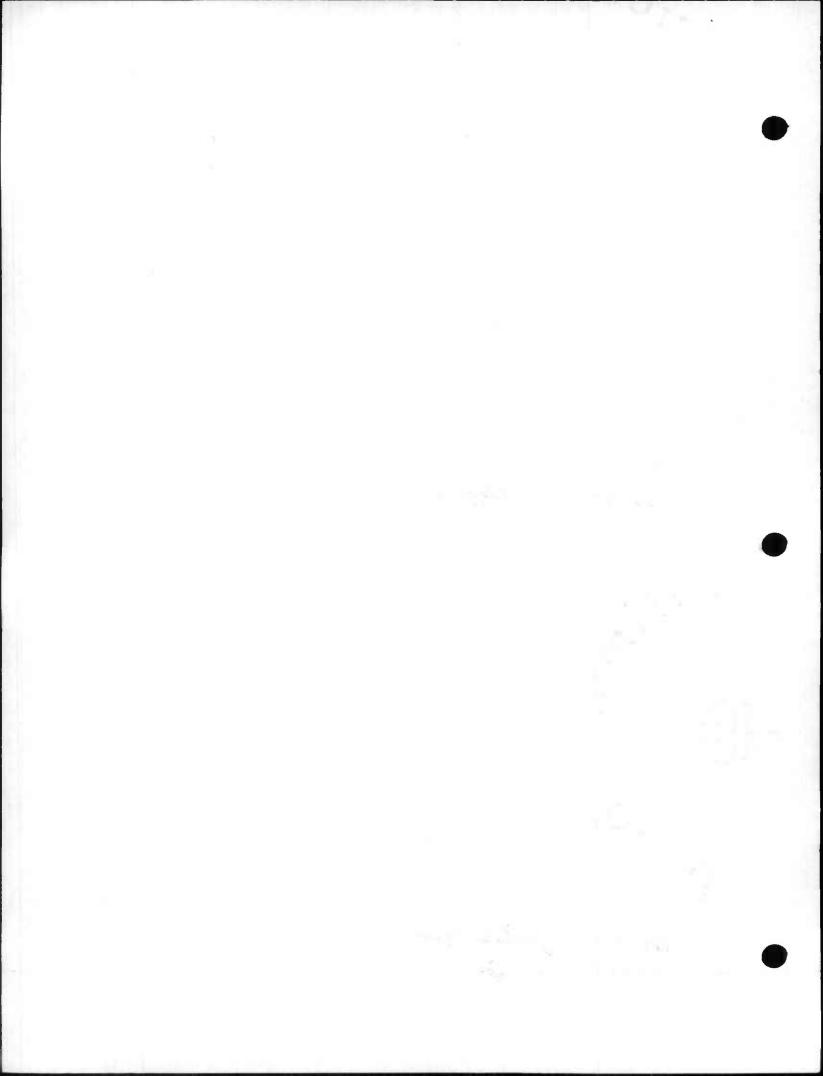
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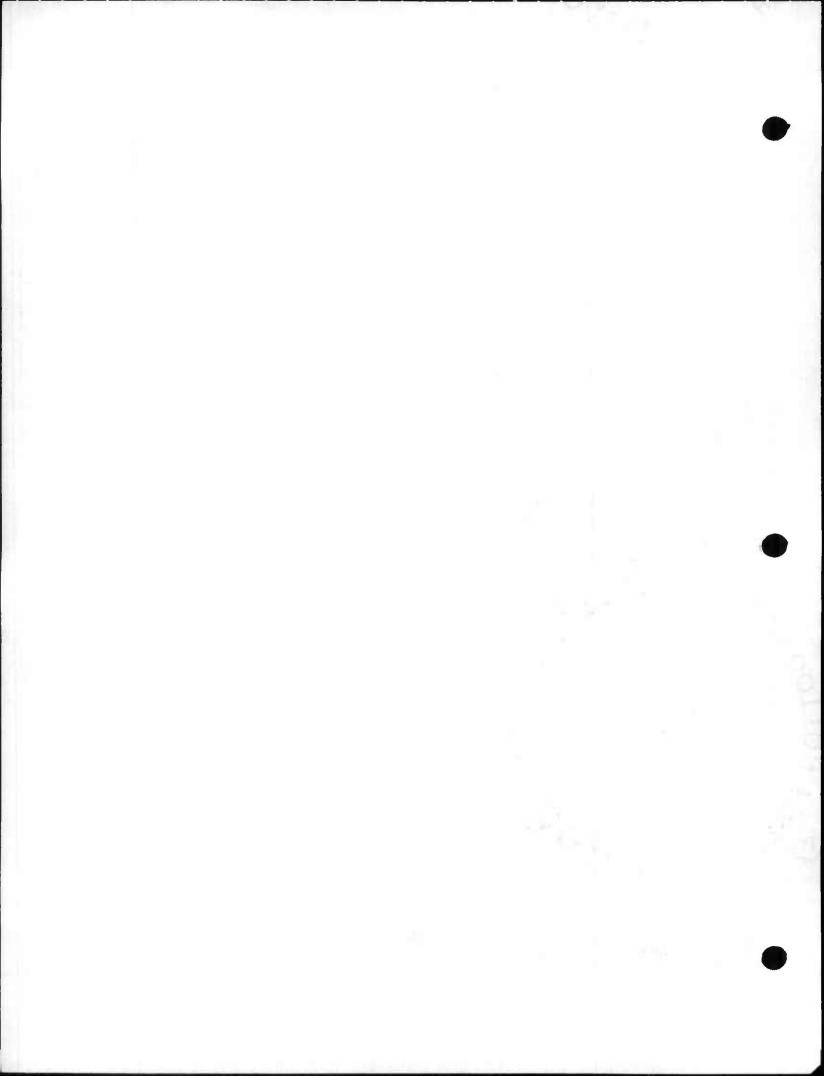
CTOR	4. SOCIAL SECURITY NUMBER 215-14-5898  9a. FACILITY NAME (if not institution, gi Saint Josephs	1 🛛 M 2 🗌 F		IF UNDER 1 YEAR IF UNDER 24 HRS.	Z. DATE OF BIRTH				
		ve street and number)		onite land	127778277 8793	of birithplace (State or Forei Country) Maryland			
RECT		•	9	Baltimore	TH 9c. COUNT	imore			
	PESIDENCE OF DECEDENT  10a. STATE  10b. COU			TOWN OR LOCATION imore City	<u> </u>	10d. INSIDE CITY LIMITS? TY YES 2   1			
FUNERAL	100. STREET AND NUMBER 2921 Overland A	venue		101. ZIP CODE 21214	U.S	en of what country? . A			
à l	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEOENT EV FDRCES? 1 X IF YES, GIVE WAR	YES 2 ND	13. WAS OECENOENT DF HISPANI If yes, specify Cuban, Mexican 1 YES 2 NO Specify:	C ORIGIN? (Specify Yes or No— Puerto Rican, etc.)	14. RACE — American India Black, White, etc. SpecWhite			
8	15. DECEOENT'S E (Specify only highest gi		16a. OECEDENT'S US	rk done during most of working	16b. KIND OF BUSINESS/INDU	ISTRY			
COMPLET	12 Years	2 Years	life. Do NOT use	epresentative	Liquor				
BE CO	17. FATHER'S NAME (First, Middle, Lest) Gabriel T For			16. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Capezio					
2	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING A	OORESS (Street and Number or Rural Re	oute Number, City or Town, State, Zip (	Code)			
	Frances T Forte			Overland Avenue					
	2ta, METHOD OF DISPOSITION  1 🖾 Burlal 2 🗆 Cremation 3 🗆 R  4 🗆 Donation 5 🗀 Other (Specify) _	lamoval from State	20b. PLACE ANO OATE DF cemetery, crematory or other	or place)	DATE 20c. LOCATION — C				
1 11-	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  Dulaney Valley Mem. Gard. 4/5/9B Coceysville  22. NAME AND ADDRESS OF FACILITY Dippel Funeral Home								
	Maritin 9. Supplied 7110 Belair Road Baltimore MD 21206								
IFICATI	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	bOUE TO (OR	AS A CONSEQUENCE OF):  AS A CONSEQUENCE OF):	SE.					
MEDICAL	PART II. Other significant condit	tions contributing to dea	ith but not resulting in	tha underlying cause given in F	Part I. 24a. WAS AN AUTOPSY PERFORMED?  1 YES 2 NO	24b. WERE AUTOPSY FIN AMILLABLE PRIOR T COMPLETION OF CO OF DEATH? 1 YES 2 N			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PLACE OF DEATH (Chor					
H	27. MANNER OF OEATH	1 Inpatient 2 ER	URY 28b. TIME		28d. DESCRIBE HOW INJURY OCCI	JRED			
B	1 Netural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not	28e. PLACE OF IN	JURY — At home, farm, str	M 1 YES 2 NO	28f. LOCATION (Street and Number of	or Rural Bouts Number			
ETED	4 Homicide datarmined	building, stc.	(Specify)		City or Town, State)				
	(Check only   CERTIFYING PH			at the time, data and place, and due t in my opinion, death occured at the t					
COMPI						Cades(a) and manner as see			
O BE COMP	2   MEDICAL EXAM	FIER		29c. LICENSE NUM	98 6 4	SIGNED (Month, Day, Your)			
38 6	2 MEDICAL EXAM	FIER		D 24	588 6 4				

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



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E H	TO THE BIINFRAL DIRECTOR's After this certificate has been signed by the attending
H	F
2	F
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certifi

		FOR STATE REGISTRAR	STATE OF MARYLAN		TMENT OF H		MENTAL HYGIE		
		1. DECEDENT'S NAME (First, Middle, Last)	Laura Mabel	Gambr	ill		2. DATE OF DEATH April 4,	1993	year 3. TIME OF DEATH
P	1	4. SOCIAL SECURITY NUMBER 216-05-8969	1 🗆 M 2 🖔 F	yrs. lest birthdey) 96 vrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.			Country)  Penna.
2, 3 should	TOR	96. FACILITY NAME (If not institution, give a Meridian Long (		Home		timore (		9c. COUNTY	Y OF DEATH
physician. burial-transit permit. Pages 1,	DIRECTOR	10e. STATE 10b. COUNTY Maryland	4	10c. CIT	r, TOWN OR LOCAT	timore (	City		10d. INSIDE CITY LIMITS? 1 X YES 2 NO
	FUNERAL	100. STREET AND NUMBER 115 Me	lrose Avenue		101	. ZIP CODE	21212		n of what country? ced States
	ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 TYES IF YES, GIVE WAR OR DATE	2 XNO	If yes, sp		NIC ORIGIN? (Specify Y in, Puerto Rican, etc.) y:	es or No— 14	4. RACE — American Indian, Black, White, etc. Specify: White
nspital or attending hed for use as the	COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION (completed)  College (1-4 or 5+)				16b. KIND OF B	USINESS/INDUS	ETRY
age 6 may be retained by the hospital director, page 5 should be detached to must be notified at once.	BE CON		iam T. Kane			٧	ME (First, Middle, Meide irginia L.	Mc Knev	
	10	Paul F. Gept		40 A	corn Cir	cle Ap		lt.,Md.	. 21286
		29e. METHOD OF DISPOSITION 1 IX Buriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LII	compte	eadowric	per place Memo		7/93 Do	orsey	Maryland
after death. Page 6 m by the funeral director, moval.		> milton	Milton J K	night Jr	Leonar	rd J. Ru	ck, Inc. 5		ford Road
certificate be executed within 24 hours at viding physician and competely filled in by Hygiene prior to burial, cremation, or remure other traumatic event, the medicing other traumatic event, the medicing process.		23. PART I. Enter the diseases, or shock, or heart failure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. OUE TO (OR AS A C	h line.		de of dying, suc	h as cardiac or res	piratory arres	tt, Approximate interval Between Onset and Death
	CERTIFICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST	DUE TO (OR AS A CO	ery &	PRter	y Dis	ease		
requires that the deen signed by the of Health and Me	MEDICAL	PART II. Other eignificant condition	a contributing to death but	not resulting	n tha underlying	cause given in		N AUTOPSY DRMED? 2 NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
N: The law ficate has bu State Dept.	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO	HOSPITAL:		OTHER:	ACE OF DEATH (Ch			
PHYSICIA this certil with the irked, or	ву рну	27. MANNER-OF OEATH  1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c. INJ URY WO		8 Other (Specify)  28d. OESCRIBE HOW	INJURY OCCU	REO
OR ATTENDING DIRECTOR: After hours after death tem 28 is mai		3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — building, etc. (Specify,	At home, farm,	street, factory, office		28f. LOCATION (Stree City or Town, Stat		Rural Route Number,
東京日	COMPLET	onel	ICIAN: To the best of my knowled ER: On the besis of examination a						
TO THE HOSPI TO THE FUNEF be filed within IMPORTANT:	TO BE C	296. SIGNATURE AND TITLE OF CERTIFIE	Jowe W.	00		29c. LICENSE NUI	A -	29d. DATE S	SIENED (Month, Day, Year)
. ^		Dr. John Bowie	M.D. 6800 Yor	k Road		e, Maryl	and		
1.7		APR 06 1993	A REMEMBER OF THE PARTY OF THE	decur					



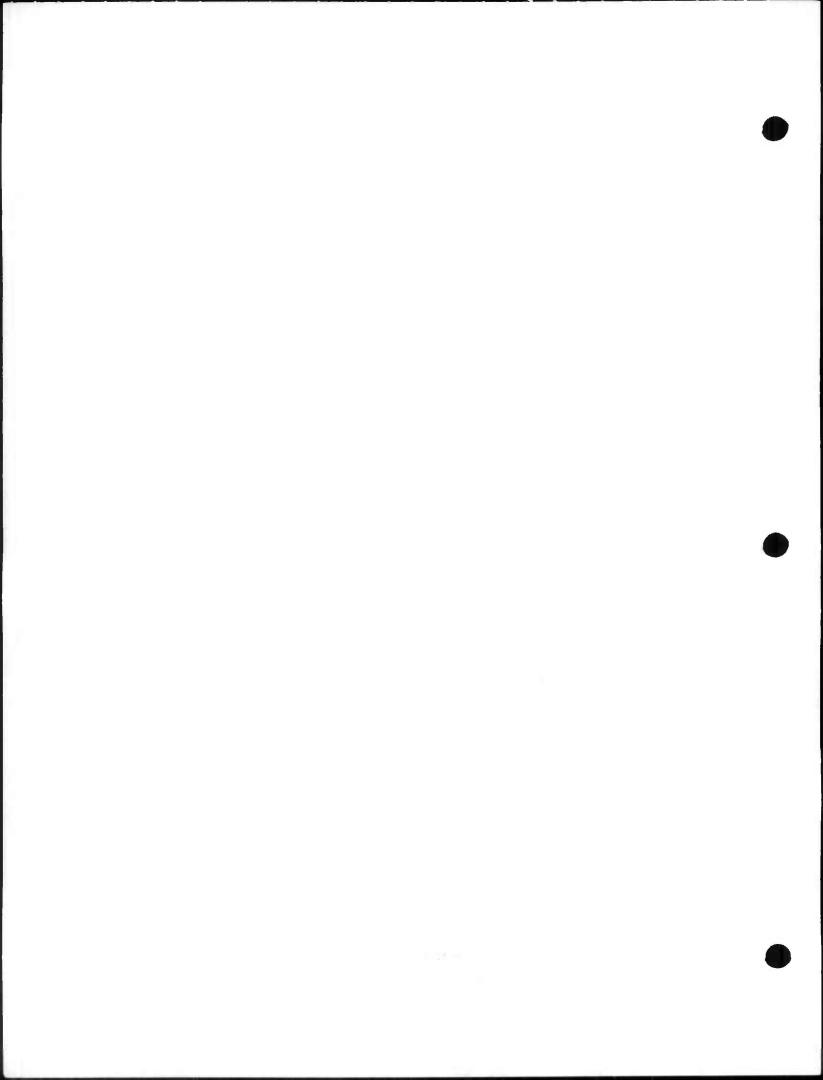
BALTIMORE, MARYLAND 21215-0020	The manner that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician.	igned by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit normal pages 1.2 sebould	or removal
DIVISION OF VITAL NECORDS, P.O. BOX 68760,	executed within 2	and completely	alth and Mental Hygiene prior to burial, cremation, or removal
80)	ficate be	physician	ne prior 1
P.0.	th certif	ending	II Hydier
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OR	s that	ned by	alth and
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(4	A	Į	hours after death with the State and Heal
>	*	æ	TS ST
OF	PHYSI	TOR: After this certif	with 1
NO	DING	After	death
ISI	ATTEN	CTOR	after
2	L 0R /	DIRE	hours

TO THE HOSPITAL OR ATTENDING PHYSICAL TO THE ACTION OF THE CHARGE DE EXECUTED WITHIN 24 nours after death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR: After this certained by the attending physician and completely filled in by the funeral director, page 5 should be detache be filled within 72 hours after death with the State of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT		ITAL HYGIENE
CERTIFICATE	OF DEATH	REG NO

	1 - STATE REGISTRAR	STATE OF MARYLAND	D / DEPARTME CERTIFICATION	NT OF HEA	LTH AND W	RENTAL HYGIEN	_	0 0 0 0 7				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH				
1	Edward	6	125			April 2		5 8 0 A M				
1 3	4. SOCIAL SECURITY NUMBER		: last birthday) IF UN	1	UNDER 24 HRS.	7. DATE OF BIRTN (Month, Day, Year)	6. BIRTHPLACE (State or Foreign Country)					
	215 40 2798	1 X M 2 □ F 50	YRS.		OCATION OF DEA	Oct. 11,	[aryland					
00	9e. FACILITY NAME (If not institution, give str	9c. COUNTY	COUNTY OF DEATN									
5	1298 Swan Driv	<u>e</u>	F	Annapo	lis		Anne	Arundel				
DIRECTOR	10a. STATE 10b. COUNTY	e Arundel		N OR LOCATION				10d. INSIDE CITY LIMITS?				
				1 YES 2 NO								
RAI	100. STREET AND NUMBER 1298 Swan Driv	10g. CITIZEN	OF WHAT COUNTRY?									
FUNERAL												
	1 Never Merried 2 Merried	12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	. ARMED 1	If yes, specify	Cuben, Mexican	C ORIGIN? (Specify Yes , Puerto Rican, etc.)	es or No— 14. RACE — American Indian, Black, White, stc.					
ВУ	3 Widowed 4 Divorced	Vietnam - 2	21 yrs.	1 U YES 23	NO Specify:			Specify: White				
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION 16e.	DECEOENT'S USUAL	OCCUPATION	working	16b. KIND OF BUS	SINESS/INDUST					
19	Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work do					rce 21 yrs.				
M	1 2	1 yr.	Postal e					ice-Recent				
	Alfred Gins					DE (First, Middle, Meiden		m3				
BE	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING ADORI			Oute Number, City or Town		Thompson				
2	Dale K. Gins (	wife)	1298 Sw			nnapolis		-/				
	20a. METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Remove	gal from State	CE AND DATE OF DISP	OSITION (Name o	1		CATION — City	or Town, State				
	4 Donation 5 Other (Specify)	4 Donation 5 Other (Specify) Metro Crematory April 3 Catonsville, MD										
	21. SIGNATURE GYFUNERAL BERVICE MCENSEE  22. NAME AND ADDRESS OF FACILITY											
Ш	Gonce FH 4001 Ritchie Hwy Balto 2122											
	23. PART L Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, abock, or heart failure. List only one cause on each line.  Approximate interval Between											
	IMMEDIATE CAUSE (Fine)											
	disease or condition a. SEPSCS  OUE TO (OR ÀS A CONSEQUENCE OF):  Z Wee 75											
_	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury CAUSE (DISEASE (DISE											
15												
S												
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A CON	SEOUENCE OF):									
B	d.											
N.	PART II. Other significent conditions	contributing to death but no	ot resulting in the	underlying ca	use given in P	art i. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO				
MEDIC	Acquired Trum	DN6	COMPLETION OF CAUSE OF CEATH?									
×			1 TES 3 NO									
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL											
100	EXAMINER?	HOSPITAL:	ОТН	ER:	OF DEATN (Chec							
Ě	27. MANNER OF CEATN	28a. DATE OF INJURY	28b. TIME OF	28c. INJURÝ		Other (Specify) 28d. OESCRIBE NOW II	pecify) IBE NOW INJURY OCCURED					
ВУР	Nstural 5 Pending Accident Investigation	(Month, Day, Year)	INJURY M	1 YES	2   NO	and describe now insulty occurred						
	3 Suicide 6 Could not be	28e. PLACE OF INJURY — At building, stc. (Specify)	home, farm, street, to	actory, office		281. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
ETED	4 Homicide determined											
COMPL	29e. CERTIFIER (Check only one) CERTIFYING PNYSICI.	AN: To the best of my knowledge,	, death occurred at the	e time, date end	place, and due to	the cause(e) end men	ner es stated.					
8	one) 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) and manner se stated.											
BE	29b. SIGNATURE AND TITLE OF CERTIFIER			290	LICENSE NUMB	DER	29d. DATE SIG	NEO (Month, Day, Year)				
2	30. NAME AND ADDRESS OF PERSON WNO	COMPLETED CAUSE OF DEATH #	TEM 27) (Time Drint)	6	13076	07	7	12 193				
	900 Rectagle			wapole	10	5 hr	1401	/				
	31. DATE FILED (Month, Day, Year)	32: REGISTRAR'S SIGNATURE		1.011	3 /	ra c	101					
	APR 06 1993	1/2 Davidson-Randa	E.									



YEAR

1993

3. TIME OF DEATH

2. DATE OF DEATH MONTH DAY

30

MARCH

ROSE

GESHEKTER

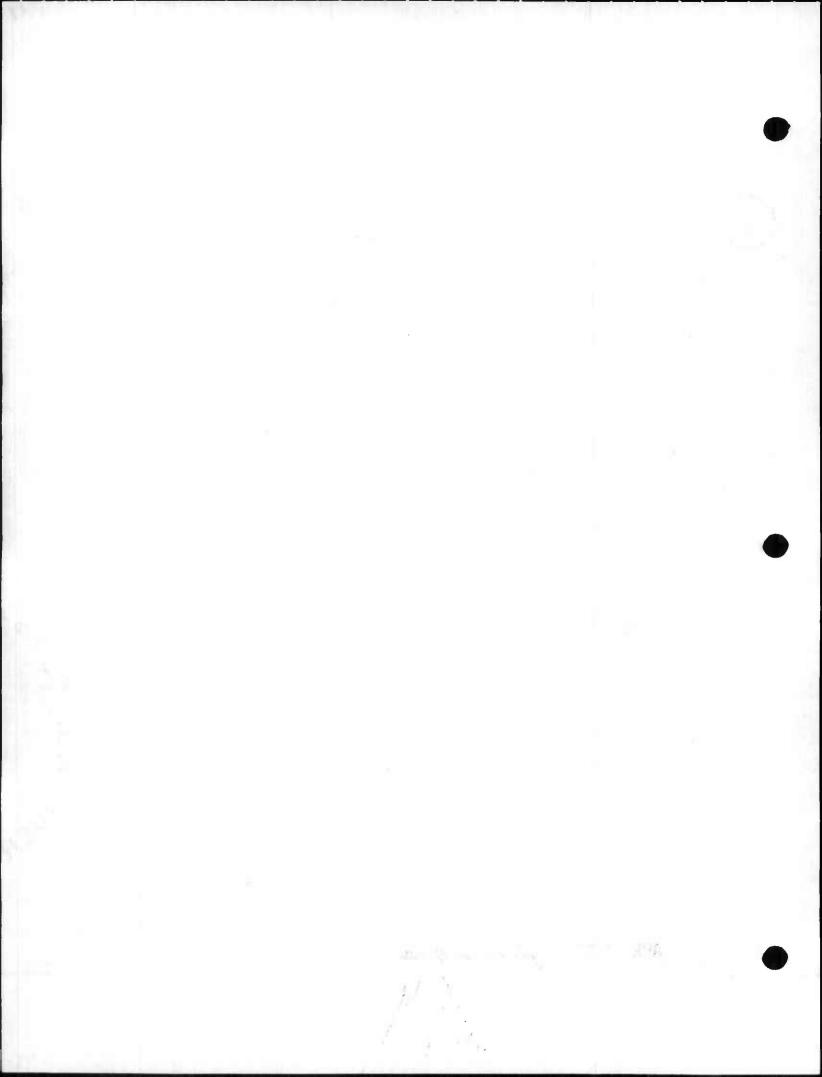
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buntal-transit be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

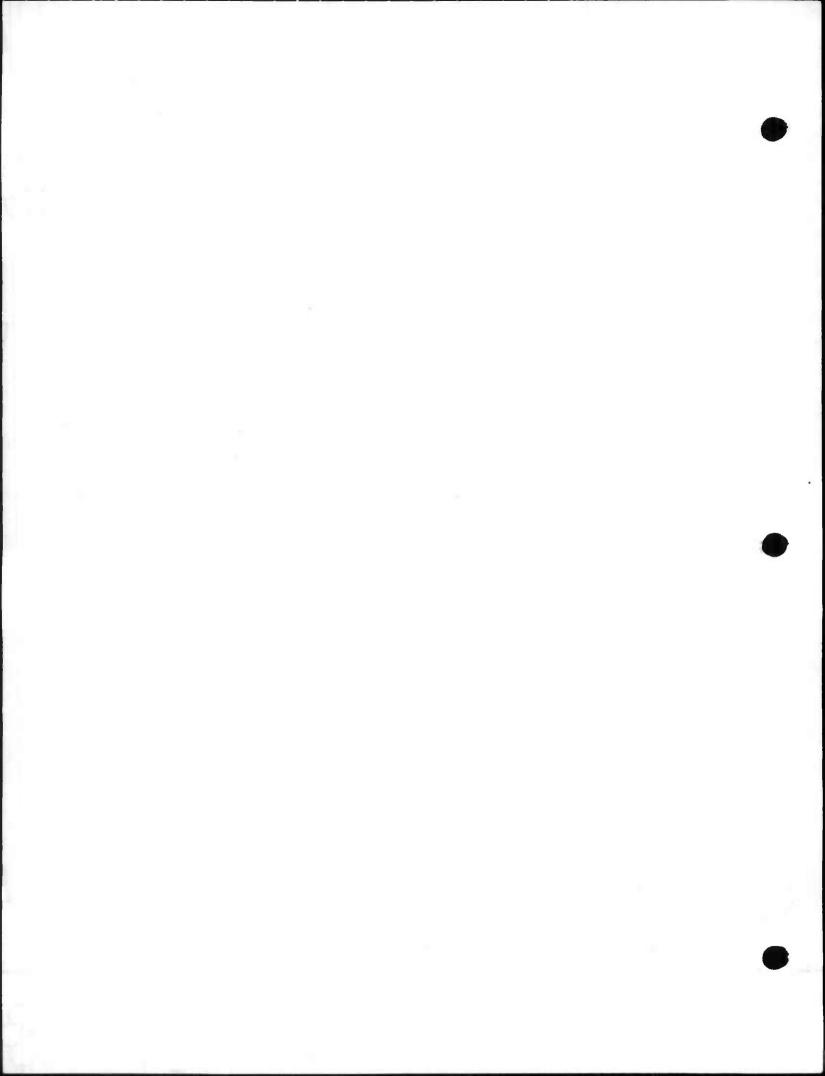
IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. las	st birthday)	IF UNDER		IF UNDER	-	7. DATE O			8. BIRTHPLA Country)	ICE (State or Foreign
- 8	713-30-0202	81	81 YAS.			NTHS DAYS HOURS MIN.		(Month, Day, Year)		11	BAD DYZE BATTO		
	9a. FACILITY NAME (If not institution, give stre	- 1101				N OR LOCATION OF DEATH					NTY OF DEAT	н	
STOR	6310 GREENSPRING	T. 506	0	BA	LTIM	IMORE							
DIRECTOR	10s. STATE 10b. COUNTY MARYLAND			10c. CITY, TOWN OR LOCATION BALT						10d. INSIDE CT LIMITS?  LIMITS?  1, YES 2 _			
FUNERAL	100. STREET AND NUMBER 6310 GREENSPRING	. 406					ZIP CODE 21209			10g. CITI	10g. CITIZEN OF WHAT COUNTRY?		
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	EVER IN U.S. AR YES 2 1 R OR DATES	YES 2 NO If yes,			SECENDENT OF HISPANIC ORIGIN? (Specify specify Cuben, Mexican, Puerto Rican, etc. ES 2 NO Specify:				or No—	American Indian, hite, etc.		
COMPLETED	1s. DECEDENT'S EDUCI (Specify only highest grade of Elementary/Secondary (0-12)		16e. DECEDENT'S USUAL (Give kind of work done life. Do NOT use retired. TEACHER			CUPATIO luring mo	ON st of workin	og	1	166. KIND OF BUSINESS/INDUSTRY  BALTIMORE CITY SCHOOLS			HOOLS
BE CON	17. FATHER'S NAME (First, Middle, Lest) CHARLES WOL	FE		18. MOTHER'S NAME (First, Middle, Malden Surname) GOLDIE GORDON								ON	
TO B	196. INFORMANT'S NAME (Type/Print) CHARLES L. GESHEKT	ER	19							er, City or Town		Code)	
	Burlet 2 Cremation 3 Remot	cemetery, cre	20b. PLACE AND DATE OF DISPOSITION (# cemetery, crematory or other place)							CATION —			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  LUCY SOL LEVINSON & BROS., INC.  6010 REISTERTOWN RD. RALTO. MD.										21215		
CERTIFICATION	23. PART I. Enter the diseasea, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, ahock, or heart failure. List only one ceuse on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  C. ACTEL OSCIEGOTIC HEART DESCRIPTION  DUE TO (OR AS A CONSEQUENCE OF):  The property arrest, and consequence of dying, such as cerdiac or respiratory arrest, and consequence of dying, such as cerdiac or respiratory arrest, and consequence of dying, such as cerdiac or respiratory arrest, and consequence of dying, such as cerdiac or respiratory arrest, and consequence of dying, such as cerdiac or respiratory arrest, and consequence of dying, such as cerdiac or respiratory arrest, and consequence of dying, such as cerdiac or respiratory arrest, and consequence of dying, such as cerdiac or respiratory arrest, and consequence of dying, such as cerdiac or respiratory arrest, and consequence of dying, such as cerdiac or respiratory arrest, and consequence of dying, such as cerdiac or respiratory arrest, and consequence of dying, such as cerdiac or respiratory arrest, and consequence of dying, such as cerdiac or respiratory arrest, and consequence of dying, such as cerdiac or respiratory arrest, and consequence of dying, such as cerdiac or respiratory arrest, and consequence of dying, such as cerdiac or respiratory arrest, and consequence of dying, such as cerdiac or respiratory arrest, and consequence of dying, such as cerdiac or respiratory arrest, and consequence of dying, such as cerdiac or respiratory arrest, and consequence of dying, such as cerdiac or respiratory arrest, and consequence of dying, such as cerdiac or respiratory arrest, and consequence of dying, and consequence of dying, and consequence of dying, and consequence of dying, and consequence of dying, and consequence of dying, and consequence of dying, a											Approximate Interval Between Onset and Death	
MEDICAL	PART II. Other significant conditions  OLD MYOCARD  ATRIAZ FIBR	NON	In the underlying cause given in Part I. 24a					PERFOR	PERFORMED?  AM CO OF		RE AUTOPSY FINDINGS ULABLE PRIOR TO MPLETION DF CAUSE DEATH?  YES 2 NO		
AN N	25. WAS CASE REFERRED TO MEDICAL	HEART ,	EAILVI	16		23.75							
SIC	EXAMINER?	HOSPITAL:	E010-4-11-1	Пес	OTHER	1:	- 1		eck only one				
Y PHYSICIAN:	27. MANNER OF DEATH  1 Natural 5 Pending	NJURY (, Year)	WOutpetient 3 DOA 4 Nursing H IURY 28b. TIME OF 1NJURY 28c. (				Home 5  Residence 6  Other (S ∴ INJURY AT WORK?  2  NO			er (Specify) SCRIBE HOW INJURY OCCURED			
TED BY	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	INJURY — At ho tc. (Specify)	IJURY — Al home, farm, streel, factory, offi				1fice 281. LOCATION ( City or Town,			(Street and Number or Rural Route Number, m, State)			
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC 2 MEDICAL EXAMINER												d manner se stated.
TO BE C	29b. SIGNATURE AND TITLE OF CLIFTURE				29c. LICENSE NUMBER D 2 2/15				29d. DATE SIGNED (Month, Day, Year)  3/31/93				
	DR. BEXNAKE	DR. BEKNALD RUBIN 8600 LIBEATY ROAD RANDRUGGED								DALLOS	21133		
	APR - 6 1993	32. REGISTRAR	S SIGNATURE	486	1								DHMH.18 Rev 1/89



	1 - FOR STATE REGISTRAR	STATE OF MARYLAN	D / DEPART	MENT OF H	EALTH AND I		GIENE 3. NO.	09309			
	1. DECEDENT'S NAME (First, Middle, Last)	R Gili	nre			2. DATE OF DE		YEAR 8:50 AM			
	4. SOCIÁL SEÉURITY NUMBER 214 30 4935  BB. FACILITY MARIE (F. not institutor, give	1 □ M 2 🛣 59	YRS.	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	Morth, Day	3-33	BIRTHPLACE (State or Foreign Country) Va •			
CTOR	ST CITALO	tha		Balti	EMOTE	EATH	9c. COUNT	Y OF DEATN			
DIRECTOR	10. STATE 10b. COUNT	Y	10с. <b>сту</b> , Ва	TOWN OF LOCAT	C.G.			10d. INSIDE CITY LIMITS? TEL YES 2 NO			
FUNERAL	3400 Arellen				21207			USA			
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	NO P	If yes, spi	ecity Cuban, Mexica 2 NO Specify	n, Puerto Rican, e	rtc.)	4. RACE — American Indian, Black, White, etc. Specify; Lack			
PLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		Me. Do NOT use	rk done during mo retired.)	ON st of working	16b. KIND	OF BUSINESS/INDUS	STRY			
COMPLET	17. FATHER'S NAME (First, Middle, Last)  Judge Robin:	son	House	wire	18. MOTHER'S NA						
TO BE	190. INFORMANT'S NAME (Type/Print) Marie Knight	3011		Hester Bouldin   NG ADDRESS (Street and Number or Flural Route Number, City or Yown, State, Zip Code)   7 Washington Ave. Balto., Md. 21207							
	29e METHOD OF DISPOSITION	Gal	ACE AND DATE OF	DISPOSITION (Na hurch	Cem.	4/6	Saxe, V	ly or Town, State			
	21. SIGNATURE OF FUNERAL SERVICE LIC	Sons Balto.,	Md. 21217								
	IMMEDIATE CAUSE (Final	a. Hun TING D	iline.			h aa cardiac or	reapiratory arrea	Approximata interval Between Onset and Death			
CERTIFICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEDUENCE OF):  C. DUE TO (OR AS A CONSEDUENCE OF):  d										
MEDICAL C	PART II. Other significant condition	24b, WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?									
HYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			26. PL	ACE OF DEATH (Ch	sck only one)		1 TYES 2 NO			
YSIC	1 YES 2 NO	HOSPITAL: 1   Inpetient 2   ER/Outpetier	nt 3 🗆 DOA   4		e 5 🗆 Residence	6 Chher (Speci	ty)				
ВУ РН	1 Netural 5 Pending 2 Accident Investigation	estigation 1 YES 2 NO									
ETED	3 Suicide 4 Homicide Could not be determined  26e. PLACE OF INJURY — At home, farm, street, lactory, office building, etc. (Specify)  26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)										
COMPL		CIAN: To the best of my knowledge: R: On the basis of examination and									
TO BE	296/SIGNATURE AND TITLE OF BERTIFIED	Mussella	9		D30/	8 2_		SIGNED (Month, Day, Year)			
		USSEL MO	3320	o BE	Mosur	VE i	BALT ,	MD 21227			
	APP 06 1993	32 CONSTRAR'S SCHATU	LE CO.								



THE MAN THE LAW requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

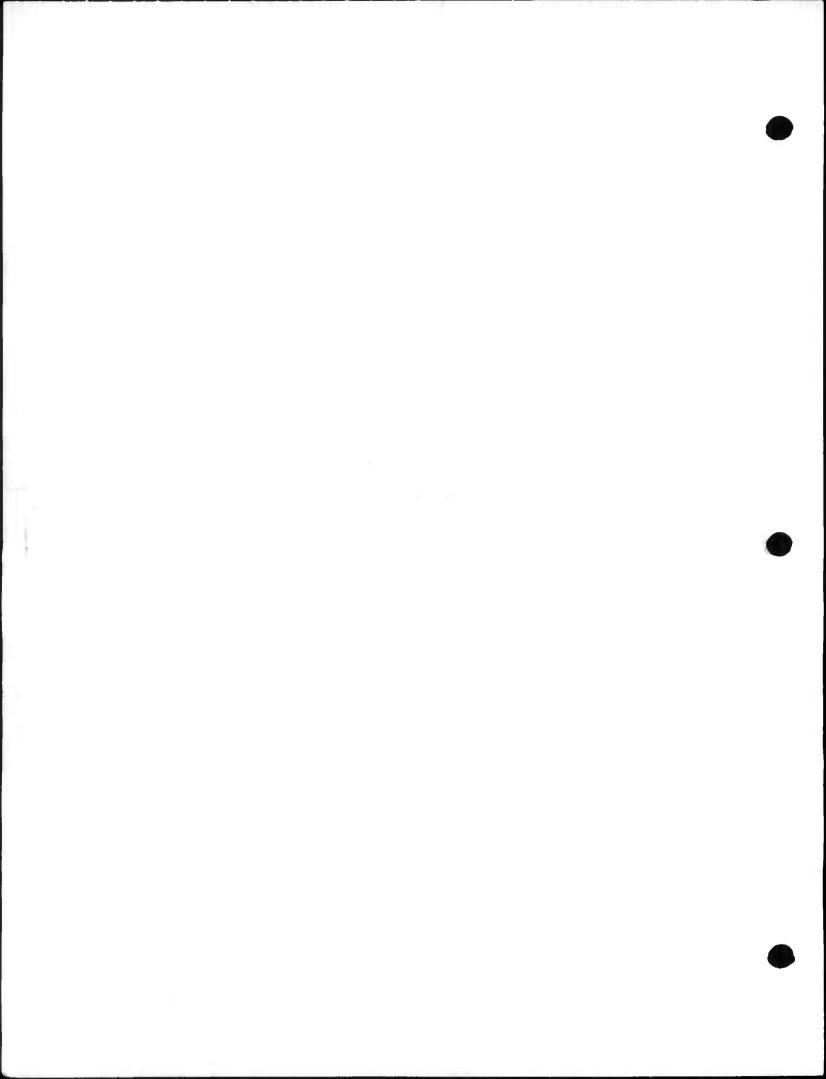
The page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

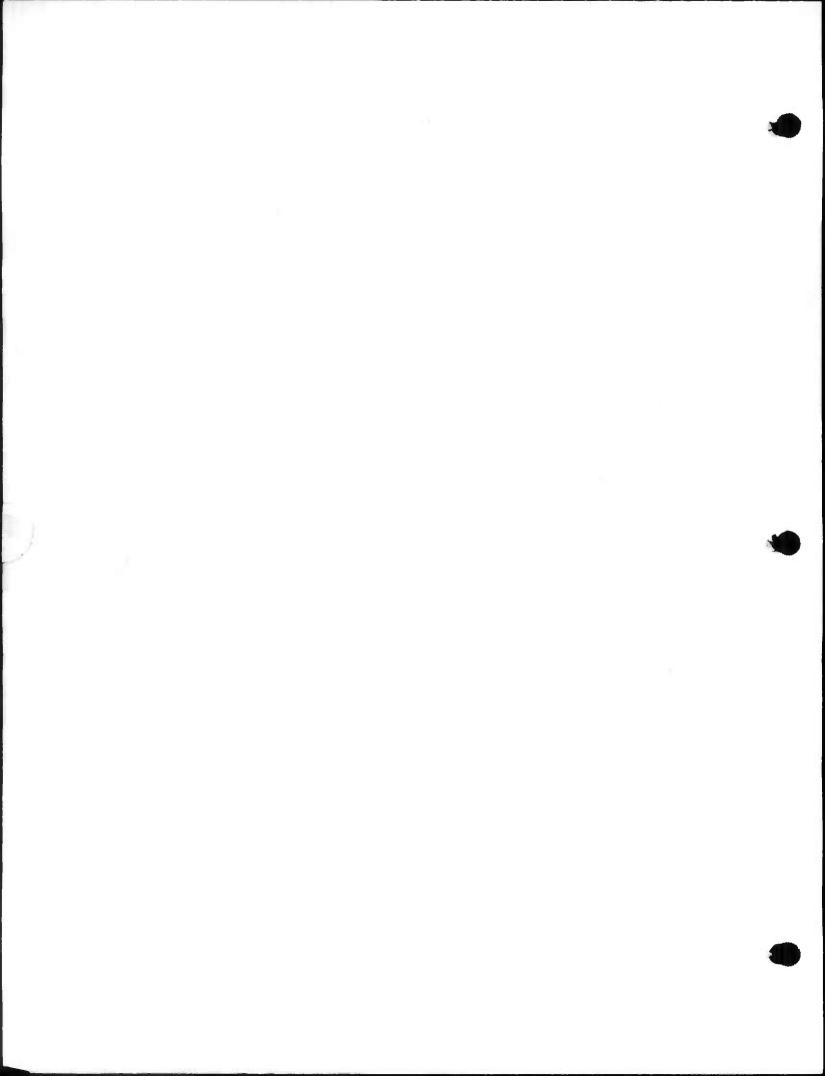
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	TO THE FUNE PART OF STORE THE CARTIFICATE has been signed by the attending physician and completely filled in by the fi	TO THE FUNETHAL OF THE TOTAL THE CONTINUE TO State Dept. Of Health and Mental Hygiene prior to burial, cremation, or removal.	TO THE FUNCTION OF COMPLETE IN CONTINUED TO SEED SIGNED BY THE ATTENDING PHYSICIAN AND COMPLETELY filled in by the filled within 72.  THE FUNCTION OF COMPLETELY FILLED SEED SEED SEED SEED SHOWS AND METTAL HYGIONE PRIOR TO BUILD COMPLETELY.  IMPORTANT: If the Continue of the medical expension of

		1 - FOR STATE REGISTRAR	STATE OF MA	ARYL	AND / DEF	PARTME	NT OF	HEALTI	H AND	MENT	AL HYGIEN REG. NO.	-			
		REGISTRAR CERTIFICATE OF DEATH  1. DECEOENT'S NAME (First, Middle, Last) 2.												3. TIME OF DE	ATH
		KATHERINE	MON 0.3	TH D/	199	YEAR 3	9:18	Έм							
	- 8	4. SOCIAL SECURITY NUMBER	5. SEX	SEX 6. AGE (In yrs. last birthday)			F UNDER 1 YEAR			7. DAT	E OF BIRTH		a BIRTI	ADI ACE /State or	-
		214-76-3043	S. MONT	HS DAYS	HOURS	MIN.	9-	9-21-59 Country)MD			G M <sup>(vr</sup>				
		9e. FACILITY NAME (If not institution, give street and number)  9b. CITY, TOWN OR LOCATION OF GEATH										9c. COUNT	TY OF D	PEATH	
	0	FRANCIS SCOTT	KEY HOSI	XEY HOSPITAL BALTIMORE											
	ច្ច	RESIDENCE OF DECEDENT  10e. STATE 10b. COUNTY	(		10c	CITY TOV	VN OR LOCA	TION						404	THE STATE OF THE S
	DIRECTOR	MD Baltimore							1001 1101000						
		6314 Cardiff Ave. 21224									JSA				
	FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT				13. WAS DE	CENDENT	OF HISPAI	NIC ORIG	IN? (Specify Yes	or No-	14. RACE	E — American Inc	dien,
	BY	1) Never Married 2 Merried 3 Widowed 4 Divorced	☐ YES 2 NO If yes, specify Cuben, Mexican, 1 ☐ YES 2 NO Specify:					n, Puerto Rican, atc.) Black, White, etc.							
	ED B		1											Black	
		15. DECEDENT'S EDUC (Specify only highest grade	completed)		16a. DECEDEN (Give kind life. Do NO	IT'S USUA I of work do IT uses metin	L OCCUPAT one during m od.)	iost of worl	king	16	b. KIND OF BUS	SINESS/INDU	STRY		
	7	Elementary/Secondary (0-12) 9 t h	College (1-4 or 5 +)		Labo		,								
nce.	COMPLET	17. FATHER'S NAME (First, Middle, Last)						18. MO	THER'S NA	ME (First	Middle, Meiden	Sumama)			_
to o	ш	William Hill									e Wil:				
Hiffed	0 8	19a. INFORMANT'S NAME (Type/Print)									nber, City or Town				
9		Janet M. Wilso	o n		621	18 F	ortv	iew	Way	./B	altimo	ore,	MD	21224	
tst p		20a. METHOD OF DISPOSITION 1  ☐ Burlel 2 ☐ Cremetion 3 ☐ Remo	oval from State	20b	. PLACE AND DA	TE OF DIS	POSITION /A	ame of		4		CATION - C			
E		Vosnetto 5 dolher (Specify) Vosnetto Memorial Gard. Dundalk, MD													
틭		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY													
Exa		WM C. MARCH F.H./1101 E. NORTH AVE.													
or other traumatic event, the medical examiner must be notified at once.		23. PART I. Enter the disease, or complications that couled the death. Do not enter the mode of dying, such as cardiec or reapiratory arrest, shock, or heart fellure. List only one couse on each line.													
E II		IMMEDIATE CAUSE (Finel													
f,		disease or condition ————————————————————————————————————													
BVe	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST.  DUE TO (OR AS A CONSEQUENCE OF):  AQUIRED IMMUNE DEFICIENCY  OUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):														
mati													-		
텔	3	cause. Enter UNDERLYING CAUSE (Disease or Injury													
		that initiated events	DUE TO (C	R AS A	CONSEQUENC	E OF):									
5	2	resulting in deeth) LAST													
injury.	ן נ	PART II. Other aignificent conditions	s contributing to d	eeth b	ut not resuiti	ng in the	underlyir	IQ Ceuse	given in	Part I.	24a. WAS AN	AUTOPSY	24b	. WERE AUTOPSY	EINDINGS
any											PERFOR	MED?		AVAILABLE PRIOR	R TO
5 I I	u II										OF DEATH?				
g :	Σ.										TINGO	IKI		1   YES 2	NO
item 23	NA I	25. WAS CASE REFERRED TO MEDICAL EXAMINER?					26. P	LACE OF	DEATH (Ch	eck only o	one)				
	200	1 X YES 2 □ NO	HOSPITAL: 1 ☐ Inputient 2 💢	ER/Outp	etient 3 DO	A 4 🗆	IER: Nursing Hor	ne 5 🗆 f	Residence	6 🗆 Oth	er (Specify)				
		27. MANNER OF OEATH	28e. DATE OF IN (Month, Day,	IJURY Year)	28b.	TIME OF INJURY	28c. IN	JURY AT		28d. OE	SCRIBE HOW IN	JURY OCCU	RED		
-	5	1 Natural 5 Pending 2 Accident Investigation				N		YES 2	□ NO						
20 0	3	3 Suicide 6 Could not be 26s. PLACE OF INJURY — At home, farm, street, factory, office 28t. I									CATION (Street e.	nd Number o	r Rurel R	loute Number,	
1															
		29e. CERTIFIER (Check only one)	CIAN: To the best of m	y knowl	ledge, death occ	curred at ti	ne time, date	and plac	e, end due	to the ca	tuse(s) and man	ner as stated	d.		
ANT. II III	3	2 MEOICAL EXAMINE		mination	n end/or investig	etion, in n	ry opinion,	death occi	ured at the	time, dat	e end place, end	due to the	cause(e	) and menner ae	stated.
		29b. SIGNATURE AND TITLE OF CERTIFIER	1 > 14.40					29c. L/(	CENSE NUM	ABER		29d. DATE	SIGNED	(Month, Day, Year,	)
	- 11	Nonald A. Wright MD  30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)  O. C. M. F. 04-01-1993													
1		30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF DE			S+2	ree+	D -	- - ] + -	imore,	M	1 -		1201
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR	S SIGN		- 0111			, Do	لالمالد	more,	Mdr	λт9	ina 2.	1201
		ADD 06 1993	E. S. K		No.										

DHMH-16 Rev 1/89



	1 - FOR STATE REGISTRAR	STATE OF I	/ MARYLAND CE		TMENT					HYGIENI REG. NO.		93	09591
	1, DECEDENT'S NAME (First, Middle, Last). Virginia S. Hi	ggins \	/IRGINIA G	RACE I	HIGGIN	IS			2. DATE OF	DEATH	Б	9545 3	8:15 AM
	4. SOCIAL SECURITY MUMPER 218-01-7170	5. SEX 1 M 2 TF	6. AGE (In yrs. Inst	t birthdey) YRS.	# UNDER	1 YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF 8 (Month)			Bally	ACE (State or Foreign
OR	9e. FACILITY NAME (# not institution, give s Stella Maris	treet and number)				WSO		ON OF DE	EATH			time	
5	RESIDENCE OF DECEDENT												
DIRECTOR	10e. STATE 10b. COUNTY			10c. CITY, TOWN OR LOCATION									Od. INSIDE CITY LIMITS?
	MARYLAND Ba					imore						YES 2 XXNO	
FUNERAL	10e. STREET AND NUMBER					101	ZIP COD					AT COUNTRY?	
밀	417 Murdock Road				T		21212				USA		
B	11. MARITAL STATUS 1 Never Merried 2 Married 3X Widowed 4 Divorced	FORCES?	NT EVER IN U.S. ARI I YES 2 XXN MAR OR DATES		- 1	If yes, sp	ecify Cubi		NIC ORIGIN? ( in, Puerto Ric y:		or No—	Specify	- American Indian, White, atc. HITE asian
	15. DECEDENT'S EDU (Specify only highest grade		16a. DE	CEDENTS	USUAL O	CCUPATIO	N et of world	na	16b. K	IND OF BUS	INESS/IND	USTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5	All I	Do NOT u	se retired.)	daring inc	or or morro		1				
<u> </u>	12			Homem	aker						N/A		
, Š	17. FATHER'S NAME (First, Middle, Last), RichardAsbury Sanford  18. MOTHER'S NAME (First, Middle, Melden Surneme)  Mary Grace Robertson												
اسا													
B	19e. INFORMANT'S NAME (Type/Print)  19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
욘	Gordon K. Higgins 5327 Tahsili Street Eugene, Oregon 97405												
	200. METHOD OF DISPOSITION  20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place)  20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place)											n, State	
	ponation 5 D Other (Specify)	4/			Cemet	ery				Park	ton, N	arylar	nd
	Denni's Stephen Xenakis M00640 22. Name and address of Facility Mitchell-Wiedefeld Home 6500 York Road Baltimore Maryland 21212												
	\ <u>-</u>				_								
	shock, or heert fallure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition Prain Tumor resulting in death)											Approximate Interval Between Onset and Death	
Z	Sequentiativ list conditions	DUE TO (OR AS A CONSEQUENCE OF): Recurrent CVA											
CATIC	Sequentially list conditions, If any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury  c.												
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):  d.											
	PART II. Other significant condition	ns contributing to	death but not r	resulting	In the ur	nderlyln	g cause	given in	Part I. 2	4s. WAS AN			VERE AUTOPSY FINDINGS
MEDICAL										PERFOR			WAILABLE PRIOR TO COMPLETION OF CAUSE
<u>E</u>			(7720)						_	YES 2	□ NO		OF DEATH?
2									_				
AN	25. WAS CASE REFERRED TO MEDICAL	1				26. PI	LACE OF 1	DEATH (C)	neck only one)				
S	EXAMINER?	HOSPITAL	☐ ER/Outpetient 3	ADD CI	OTHER 4 C No.		<b>■</b> 5 □ 8	Ingldance	6 🗆 Other (	Speciful			
PHYSICIAN:	27. MANNER OF DEATH	28a. BATE O	F INJURY	28b. TH	WE OF	28c. IN.	URY AT	in and a rice	· ·	RIBE HOW I	NJURY OC	CURED	
	1 Natural 5 Pending	(Month,	Diec Mayo		JURY		YES 2	□ NO					
ВУ	2 Accident Investigation 3 Suicide 6 Could not be	284 PLACE	OF INJURY — At he	ome, farm,	street, fac	tory, offic			281. LOCAT	ION (Street I	and Number	or Rural Ro	ute Number,
	4 Homicide determined	building	y etc. (Specify)						City or	Town, State)			
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYS												and manner as stated
BE CO	29b. SIGNATURE AND TITLE OF CERTIFIE		100					_	MBER 04				Month, Day, Year)
ТОВ	30. NAME AND ADDRESS OF PERSON WI	10 COMPLETED CAI	USE OF DEATH (ITE	M 27) (Typ	e, Print)		/				• ~	10/	. «
	Eddie Nakhuda :	2300 Du	laney \	/all	ey F	RD.	Tow	son	, Mai	ylar	nd 2.	1204	
	31. DATE FILED (Month, Day, Year)  APR 0.6 1993	32. REGISTA	MACON-ROM	dete									
	TAK AA 1999	4											



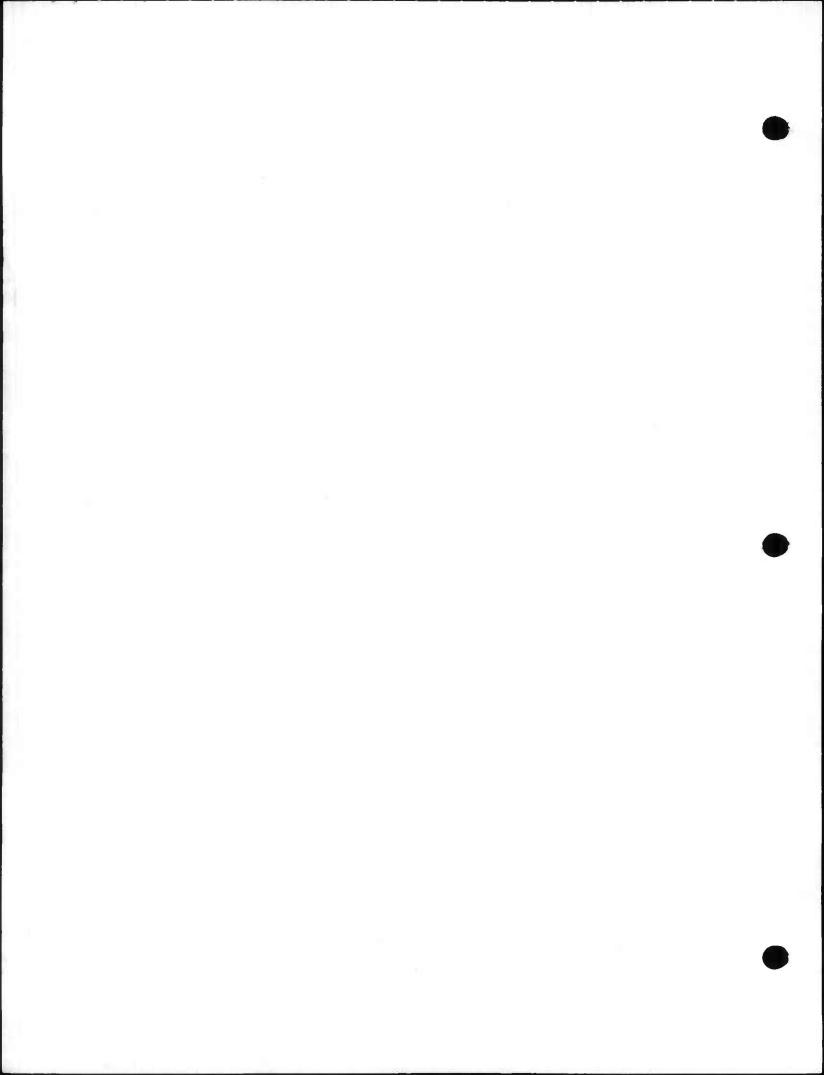
BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA		TMENT OF H		MENTAL HYGIEI		0 0 0 0 0				
b	1. DECEDENT'S NAME (First, Middle, Last)	HEDDDING				2. DATE OF DEATH		3. TIME OF DEATH				
	LUZ EVELYN  4. SOCIAL SECURITY NUMBER	HEPPDING	n yrs. last birthday)			4 0:						
0	214-82-4263		4 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 11-05-19	, ,	BIRTHPLACE (State or Foreign Country) ERTO RICO				
	Sa. FACILITY NAME (If not institution, give s	treet and number)	-	9b. CITY, TOWN C	OR LOCATION OF D		9c. COUNTY					
OR	NORTH ARUNDEL HOS	PITAL		GLEN	BURNIE		ANNE	ARUNDEL				
DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNT	Y	10c. CITY	, TOWN OR LOCAT	TON			10d. INSIDE CITY				
PIO	MARYLAND AN	NE ARUNDEL		RIVIERA	BEACH			LIMITS?  1 YES 2 NO				
ME	10e. STREET AND NUMBER			101	ZIP CODE		OF WHAT COUNTRY?					
FUNERAL	136 GREENLAND BEA				1226		U.S.A					
	1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 TYPES IF YES, GIVE WAR OR DA	2 NO	If yes, sp	ecify Cuben, Mexic	NIC ORIGIN? (Specify Young, Puerto Rican, etc.)		RACE — American Indian, Black, White, etc.				
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR ON DA	i es	1 U YES	2 NO Specif	y:		Specify: WHITE				
里	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S (Give kind of w life. Do NOT use	ork done during mo	N st of working	16b. KIND OF BU	ISINESS/INDUST	RY				
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+) NONE	HOMEMA			OWN HO	ME					
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		понын	АКШК	18. MOTHER'S NA	ME (First, Middle, Maide	Sumeme)					
BE C	CHARLES YARISH, SR. LUZ BELTRAN											
5	II 190 INFORMANT'S NAME (Type/Print)											
	20a. METHOD OF DISPOSITION	20b.	PLACE AND DATE O	F DISPOSITION (Na	me of	DATE 20c. L	DCATION — City	or Town, State				
- 3	1 TX Burlel 2 Cremation 3 Removel from State cemetary, crematory or other place) 4 Donation 5 Other (Specify) GLEN HAVEN MEMORIAL PARK 1993 GLEN BURNIE, MARYLAND											
1	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME											
	1 SECOND AVE., S.W., GLEN BURNIE, MD. 21061											
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reepiratory arrest, and a cardiac or reepiratory arrest, interval Between Onset and Death  IMMEDIATE CAUSE (Final											
	IMMEDIATE CAUSE (Final disease or condition											
	resulting in deeth)	DUE TO (OR AS A	CONSEQUENCE OF	1 6	Indra	me						
NO												
ATI	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING											
Ę	CAUSE (Disease or Injury that Initiated events DUE TO (DR AS A CONSEQUENCE OF):											
CERTIFICATION	resulting in death) LAST											
AL C	PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY FINDINGS PERFORMED?  AMALABLE PRIOR TO											
EDIC						1 _ YES		ANAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
Σ	**					_		1 TES 2 NO				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL			26 Pt	ACE OF DEATH (C)	neck only one)						
SIC	EXAMINER? 1 YES 2 NO	HOSPITAL: 1   Inpatient 2   ER/Outpa	itlent 3 DOA	OTHER:		6 Other (Specify)						
PHY	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c. INJ		28d. DESCRIBE HOW	INJURY OCCURE	D				
BY	1 Natural 5 Pending 2 Accident Investigation	90 - DI 405 OF WHITE			ES 2 ND							
COMPLETED	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY - building, etc. (Specif	— At home, farm, si	treet, factory, offici		28t. LOCATION (Street City or Town, State		ural Route Number,				
PLE	29s. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of my knowle	rdys, death occurre	d at the time, date	and place, and due	to the cause(s) and m	nner as stated.					
OMI		Bi-On the besis of examples						use(x) and menner as stated.				
ш	290. SIGNATURE AND TITLE OF CERTIFIER	. / L	~		1294. LICENSE MA	WBER	29d. DATE SIG	INED (Month, Day, Year)				
TO B	20 MAME AND STREET		E-The	1 1	DIA	tof	16-	2-93				
	30. NAME AND ADDRESS OF PERSON WHO	Wu, M.D., 16	114 (ITEM 27) (Type,	Crain 1	Highway	, #306,	Glen E	Burnie, MD.				
	APR 06 199	32. RESISTAT DEEMA	Sept-ijande	SC.								



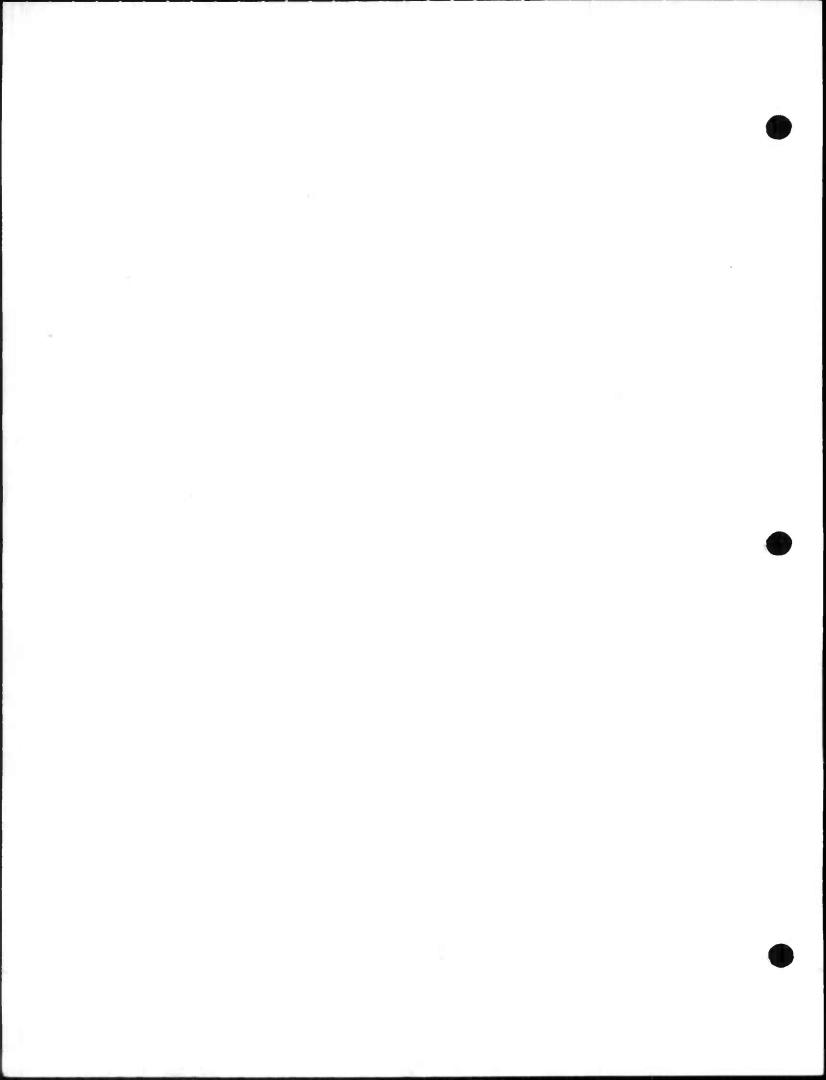
4	affe
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5	within
200 400	executed
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	law requires that the death certificate be executed w
-	death
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5	that
	requires
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	9
	AYSICIAN.
	9
	AL OR ATTENDING PHYSICIAN: TO
	S
•	-

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death cartificate be executed within 24 nours arise reash. rays to make the incomment of the sas the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

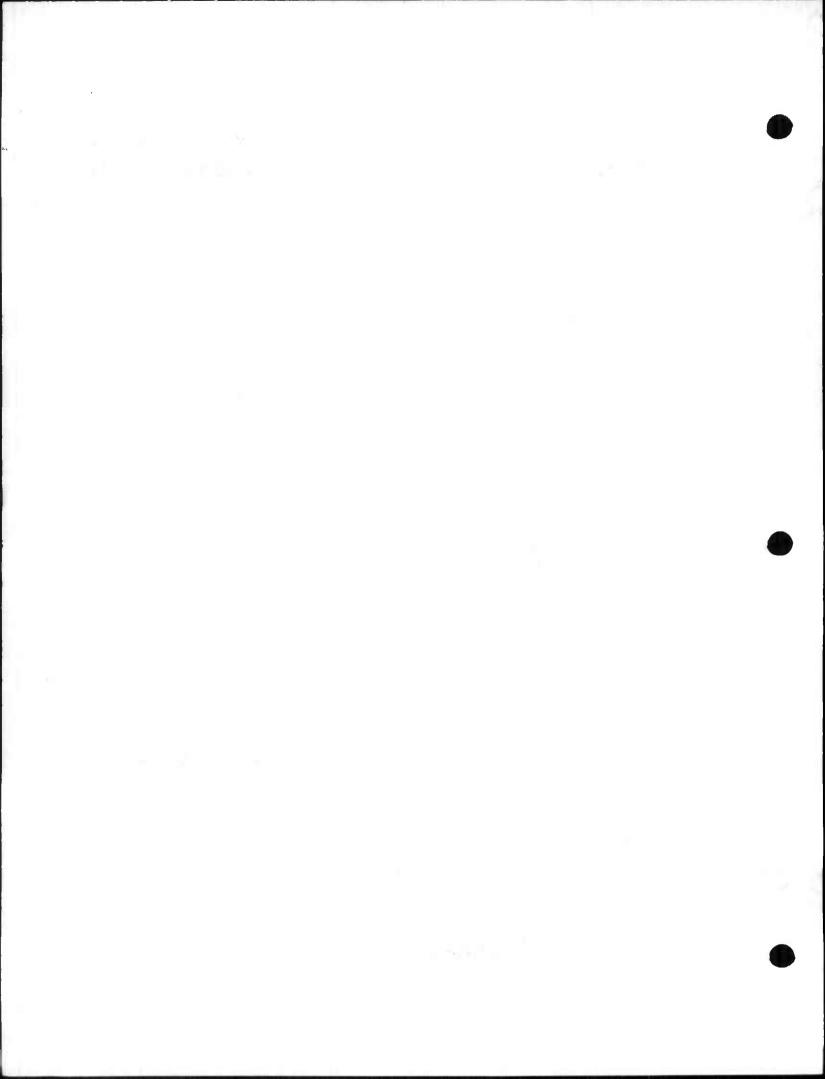
STATE	0F	MARYLAND / DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGIE	NE
		CERTIFICATE	0	F DEAT	'H		DEG N	0

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF H	EALTH AND	MENTAL HYGIENI REG. NO.	E					
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH				
		ERINE HO	FFMAN			04 03		0600 P M				
	4. SOCIAL SECURITY NUMBER	A 1000		F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	a. BiPT	BIRTHPLACE (State or Foreign Country)				
	219-16-6195	¹□M²□X 85	YRS.	ONTHS DAYS	HOURS MIN.	06-04-190	_	GINIA				
DIRECTOR	90. FACILITY NAME (If not institution, give st NORTH ARUNDEL HO		PEATH 9c. COUNTY OF DEATH ANNE ARUNDEL									
딥	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY	,	Inc. CITY	TOWN OR LOCAT	104			10d. INSIDE CITY				
	MARYLAND A	NNE ARUNDEL		GLEN BU	JRNIE		1 YES 2 NO					
FUNERAL	21 HARRIETT DRIV	E			21060		U.S.A.	WHAT COUNTRY?				
SN	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED			NIC ORIGIN? (Specify Yes		25 A				
COMPLETED BY FL	1 Never Married 2 Married 3 X Widowed 4 Divorced	FORCES? 1 YES	2 X NO	If yes, sp	City Cuban, Mexica	in, Puerto Rican, atc.)		E — American Indian, ck, White, etc. city: WHITE				
	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed)  College (1-4 or 5 +)	16a. DECEDENT'S US (Give kind of wor life. Do NOT use i	k done during mo	ON st of working	16b. KIND OF BUS	INESS/INDUSTRY					
P		ONE	MAINTENA	NCE		MARTIN -	MARIET	ΓA				
S	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Malden S						
BE (	GEORGE HARRISON				GRACE	LAWSON						
2	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DORESS (Street a	nd Number or Rural	Route Number, City or Town						
	ALICE L. ROGERS		ARYLAND 21060									
	20a. METHOD OF DISPOSITION  1/2 Burlel 2 Cremation 3 Removal from State  20b. PLACE AND DATE OF DISPOSITION (Name of cametery, cramatory or other piace)  MEADOWRIDGE MEMORIAL PARK 1993  ELKRIDGE, MARYLAND											
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											
	SINGLETON FUNERAL HOME 1 SECOND AVE., S.W., GLEN BURNIE, MD. 2106											
	23. PART I. Enter the diseases, or c shock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	Massi N	CONSEQUENCE OF	n ord	rascul	by our		Approximate Interval Between Onset and Death				
CERTIFICATION	disease or condition resulting in death)  Massive Cereboro vascube arisinglish of the conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  Massive Cereboro vascube arisinglish of the conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  Massive Cereboro vascube arisinglish of the conditions o											
PHYSICIAN: MEDICAL (	PART II. Other algnificant conditions	a contributing to death be	it not resulting in	the underlying	cause given in	Part I. 24a. WAS AN A PERFORE 1 YES 2	MED?	24b. WERE AUTOPSY FINDINGS AMAIL ABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
2					<del> </del>	_		1 YES 2 NO				
ICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	0	26. PL	ACE OF DEATH (Ch	eck only one)						
₹ ¥	1 TYES 2 NO	1 Inputiont 2 ER/Output 28a. DATE OF INJURY	ttlent 3 DOA 4	☐ Nursing Hom		6 Other (Specify)						
BY PI	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	28b. TIME C	URY AT RK? 'ES 2 NO	26d. DEŞCRIBE HOW IN	JURY OCCURED						
	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY building, atc. (Speci	261. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
COMPLETED		CIAN: To the best of my knowle										
Į S	2 MEDICAL EXAMINER	R: On the back of examination	and/or investigation,	in my opinion to	self-occured at the	time, date end place, end	due to the ceuse	a) and menner as stated,				
BE	290. SIGNATURE AND TITLE OF CERTIFIER 204 JOHN SIGNI											
<u>و</u> ا	30. NAME AND ADDRESS OF PERSON WHO	COMBI ETEN ONIOS OF THE	THE OTHER OF THE		D14	136	7-17	5				
	DR DALJIT S SAWHA	VEY_M_D16	OO CRAIN	Ť	Y SM GI	EN BURNIE	MD 210	61				
	31. DATE FILEO (Month, Day, Year) ADD 06 1993	32. HEGISTBAR'S SIGNA	TURE			,						

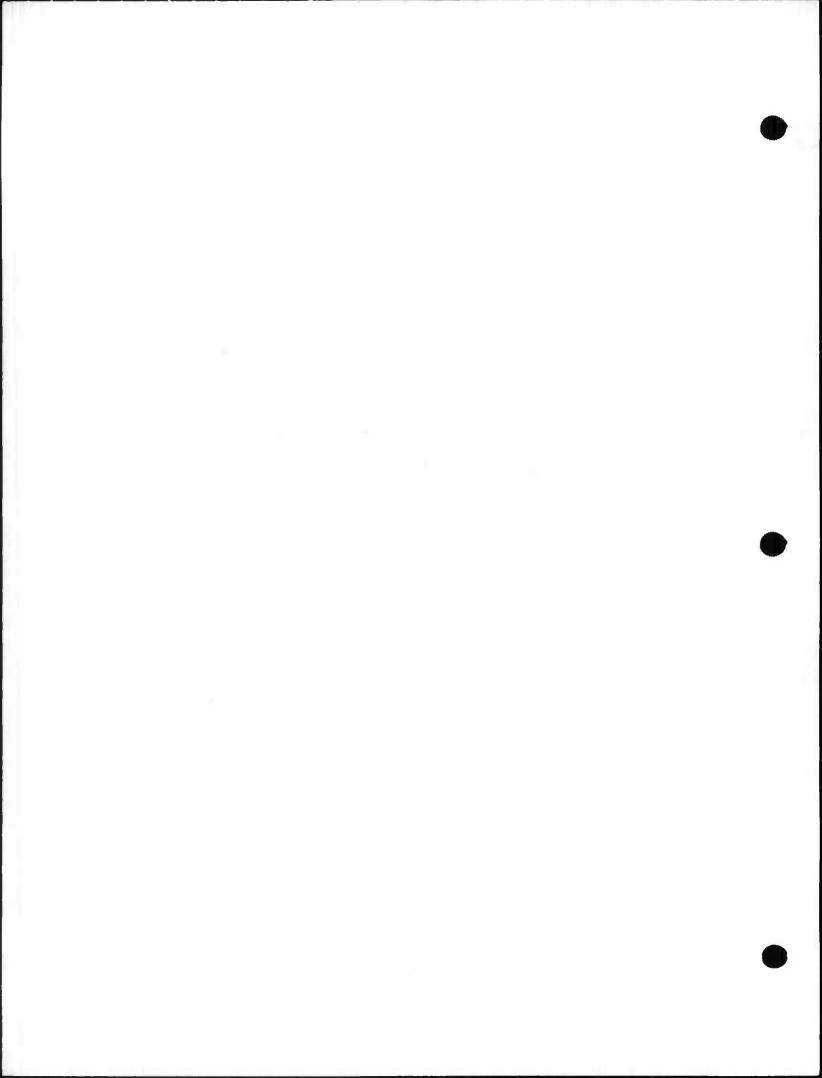


	CONTRACTOR OF THE PROPERTY OF
examiner must be notified at once.	IMPORTANT: It item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
in the state of th	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
e funeral director, page 5 should be detach	TO THE DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach
death. Page 6 may be retained by the hos	TO THE STATE OF ALLENDING PHYSICIAN: The IAW requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos

	FOR		STATE OF B	AADVI AA	ID / DEBAI	THENT !	VE 10541711 441				33	09594
	1 - STATE REGISTRAR		SIMIE UF I	MANTLAN			OF DEATH AN	D WENI	AL HYGIEN REG. NO	_		
	1. DECEDENT'S NAME (FIS Elizabet	Ha	ulplipe	Eli	zabeth	Haulp:	ilipe		TE OF DEATH	w - 9.	YBAR 3. TI	ME OF DEATH
	4. SOCIAL SECURITY NUM  220-22-	7517	5. SEX  6. AGE (in yrs. lest birthe			MONTHS DAYS HOURS MIN.			TE OF BIRTH onth, Day Year) - 13-12		BIRTHPLACE COUNTRY)	E (State or Foreign
TOR	9a. FACILITY NAME (II not II  Stella Ma	ris Ho		1911		Tows	OWN OR LOCATION OF	FDEATH	y of DEATH imore			
D BY FUNERAL DIRECTOR	10a. STATE MD	10b. COUNT	imore		Inc. Cri	TY, TOWN OR I	OCATION				INSIDE CITY LIMITS? YES X XNO	
	10e. STREET AND NUMBER						101. ZIP CODE 21204			N OF WHAT		
	506 Park A  11. MARITAL STATUS  1 Never Merried 2 S  3. Widowed 4 Dive	Married Orced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2	ON	If yo	DECENDENT OF HIS	PANIC OŘI kican, Puerl ecily:	GIN? (Specify Yes to Rican, etc.)			merican Indian, la, atc.
Ë	(Specify on	EDENT'S EDU y highest grade	JCATION e completed)	16	e. DECEDENT'S (Give kind of life. Do NOT u	work done duri	IPATION ng most of working	31	66. KIND OF BUS	SINESS/INDUS	STRY	
COMPLETED	Elementary/Secondary (		College (1-4 or 5 +	Salesla				Depar	rtment	Store	3	
BE CO	17. FATHER'S NAME (First, Middle, Lest)  Charles Vesely  18. MOTHER'S NAME (First, Middle, Maiden Surname)  Mary Korecky											
101	Genevieve Ann Cozzubo  19a. INFORMANT'S NAME (Type/Print)  Genevieve Ann Cozzubo  19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zlp Code)  Baltimore MD 21204											
	206_METHOD OF DISPOSITION  1  Burlai 2  Cremation 3  Removal from State  4  Donation 5  Other (Specify)											
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  Marken D. Dippel Funeral Home  7110 Belair Road  Roal times of MD 21206											
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, shock, or heert failure. List only one ceuse on each line.											Approximate Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):											
MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WKS AN AUTOPSY PERFORMENT  1 YES 2 NO									MED7	COMP OF DE	AUTOPSY FINDINGS ABLE PRIORI TO LETION OF CAUSE (ATH) YES 2   NO
A.	25. WAS CASE REFERRED TO			_/	)							
PHYSICIAN:	EXAMINENT 1 VES 2 NO	O MEDICAL	HOSPITAL:	ENfortuetie	M DOA	OTHER.	6. PLACE OF DEATH		- 4	1.40.4		
놡	27. MANNER OF DEATH		28s. DATE OF (Month, Da	MUURY	266. TIM		INJURY AT	-	ESCRIBE HOW IN	A	-	
BY F		Pending Investigation	(mone)		IN.	4.0	WORK?					
		Could not be determined	28e. PLACE Of building,	te. (Specify)	Al home, farm, r	street, factory,	office	29f. LC	CATION (Street a ly or Town, State)	nd Number or	Rurel Route No	umber
COMPLETED	29a. CERTIFIER CONTROL (Check only one) 2 MEDI	FYING PHYSI CAL EXAMINE	ICIAN: To the best of	my interested an	e, death occurr dfor investigatio	ed at the time, in, in my opini	date and place, and o	tue to the c	ause(s) and men	ner so stated.	avee(s) and o	nanner as stated.
BE C	200 SIGNATURE AND TITLE OF CONTINUED										IGNED (Month	
TO B					3000000		D 155	04		▶ 04	1/05/9	3
۲	E. Nakhuda M.D., 2300 Dulaney Valley Road, Towson, Md 21204.											
	APR 06 199	20000	relia Davidson	Hond	M.							
	HEK 0 0 133	10 1	1-024	.1.								



	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	RTMENT OF I	HEALTH AND		NE	3 09595					
	1. DECEDENT'S NAME (First, Middle, Last) EMERY	Α.		J(	ONES	REG. N 2. DATE OF DEATH MONTH 04 (	DAY	year 3. TIME OF DEATH 3 5:45 PM					
	4. SOCIAL SECURITY NUMBER 213-62-8101		(In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 10-19-	54	BIRTHPLACE (State or Foreign Country)					
CTOR	98. FACILITY NAME (If not institution, give s				OR LOCATION OF D		9c. COUNT	Y OF DEATH					
AL DIRECT	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNTY			Y, TOWN OR LOCA	TION			10d. INSIDE CITY LIMITS?					
	100. STREET AND NUMBER 2014 E. 31st	91,+		Baltimo "	M. ZIP CODE		1.2	1 X YES 2 NO					
BY FUNERAL	11. MARITAL STATUS  1 Never Married 2 Married  3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1   YES IF YES, GIVE WAR OR DA	2XXNO	If yes, s	21215 CENDENT OF HISPA pecify Cuben, Maxico s 2 No Specification Specifi	NIC ORIGIN? (Specify an, Puerto Rican, etc.) y:	USA Yes or No — 1	4. RACE — American Indian, Black, Whita, etc.					
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 11th	CATION completed)  College (1-4 or 5+)	16a. DECEDENT'S (Give kind of life. Do NOT u	USUAL OCCUPATI work done during m se retired.)	ON ost of working								
5 Lu	17. FATHER'S NAME (First, Middle, Lest) Emery A. Jones	Sr.				AME (First, Middle, Meiden Surmerne) ha Williams							
TO BI	19s. INFORMANT'S NAME (Type/Print)  Jurisha Jones		al Route Number, City or Town, State, Zip Code) (Baltimore, MD 21215										
	20a. METHOD OF DISPOSITION  1 D Burist 2 Cremetion 3 Remo		PLACE AND DATE	OF DISPOSITION (N	eme of	OATE 20c.	LOCATION - CI	ty or Town, State					
	21. SIGNATURE OF FUNERAL SERVICE LIC	WM C. MARCH F.H./1101 E.NORTH AVE.  23. PART I. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest,   Approximate											
event, the medical	23. PART (I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate interval Between Onset and Define disease or condition resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):												
CERTIFICATION	Sequentially list conditions, if any, laading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):												
MEDICAL	PART II. Other algnificant condition	a contributing to death be	g cause given in		AN AUTOPSY ORMED? 2 NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 M YES 2 NO							
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		28. P	LACE OF OEATH (Ch	eck only one)							
E	1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending	1 Inpatient 2 ER/Outp	28b. TiM	E OF 28c. IN.	JURY AT ORK?	8 Other (Specify)  26d. DESCRIBE HOV	INJURY OCCU	RED					
- 1	2 Accident Investigation 3 Suicide 8 Could not be 4 Nomicide detarmined	28e, PLACE OF INJURY building, stc. (Spec	— At home, farm,		YES 2 NO	28f. LOCATION (Street and Number or Flural Route Number, City or Town, State)							
COMPLETED	29s. CERTIFIER (Check only one) 1 CERTIFYING PNYSIC	CIAN: To the best of my knowles: On the bests of examinetion	edge, death occurr	ed at the time, date	and place, and due	to the cause(s) and n	nanner sa stated	cause(s) and manner as stated.					
BE	296. SIGNATURE AND TITLE OF CERTIFIER	1014		, and a particular of	29c. LICENSE NUI	ABER	29d. DATE S	SIGNED (Month, Day, Year) $3-1993$					
2 2	30. NAME AND ADORESS OF PERSON WHO	COMPLETED CAUSE OF OE				altimore							
	31. DATE APR 108 11993	AS RECIPORATION	Mandage		, D	AT CIMOLE	, Plat	y rana 2.1201					



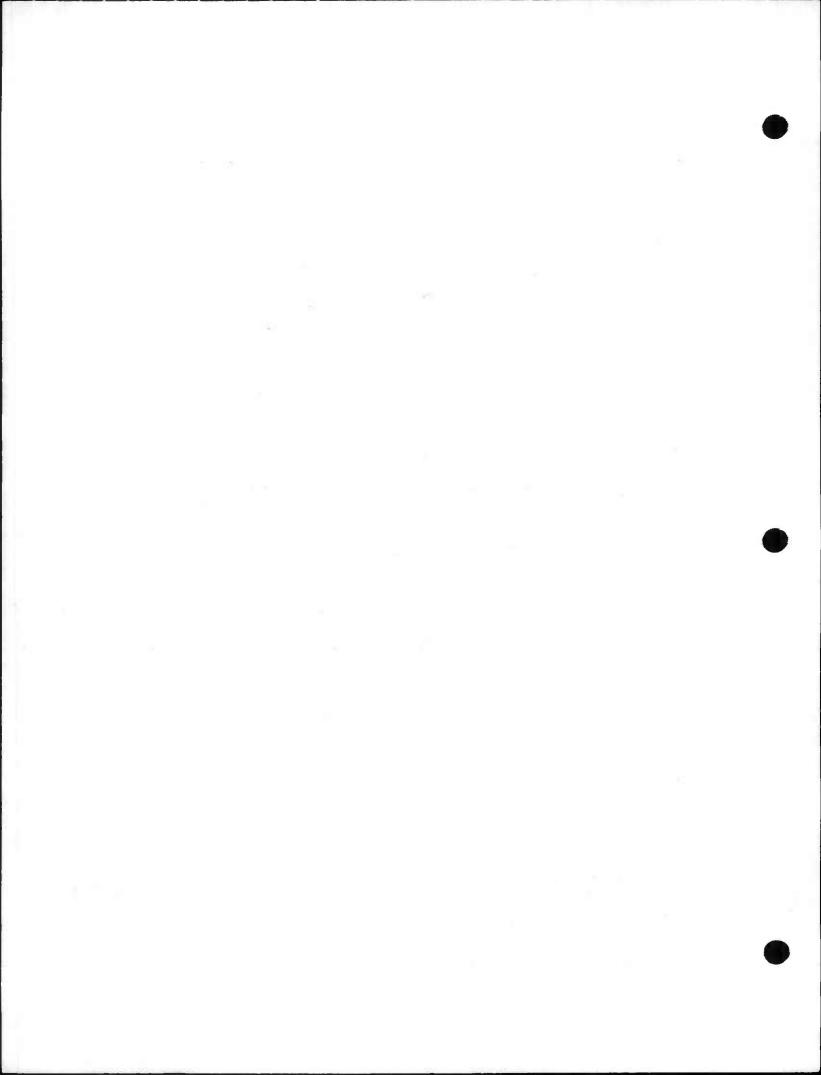
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TO THE HOSPITATION OF PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filled within American with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	TMENT OF H	HEALTH AND DEATH		YGIENE EG. NO.	20	09396			
	1. DECEDENT'S NAME (First, Middle, Last)	SARA ELIZA	BETH JEC	ELIN		2. DATE OF I	DEATH	9 <sup>YEAR</sup>	3. TIME OF DEATH 7.04PM			
	4. SOCIAL SECURITY NUMBER 220-30-7390	1 □ <b>M X1XX</b> 9	(In yrs. leat birthday) 9 yrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF E (Month, De 9-5-	y, Year)					
TOR	98. FACILITY NAME (If not institution, give s	HOS PI	TAL	-	ALTI	EATH MDRS	1. De					
DIRECTOR	Maryland N/A	Υ	0.71	v, TOWN OR LOCAT				10d. INSIDE CITY LIMITS? 1XXYES 2 NO				
FUNERAL	4117 Elderon Av	/enue		. 101	21215	1	10g. CITIZEN OF WHAT COUNTRY?					
B	11. MARITAL STATUS  1 Never Merried 2 Merried  3 X Volumed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 1 YES IF YES, GIVE WAR OR D	XXNO	If yes, sp	ecity Cuban, Mexico NO Specific	an, Puerto Rican	pecify Yea or , etc.)	No— 14. RAG Bla Spe	CE — American Indian, ck, White, etc. cdy: White			
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Give kind of the life. Do NOT us	USUAL OCCUPATION Work done during more retired.)	ON est of working	16b. KIN	D OF BUSIN	ESS/INDUSTRY				
OMP.	17. FATHER'S NAME (First, Middle, Last)	4	RN				Hospi					
BE C	ELISHA GIVAN ELIZABETH PARSONS											
5	196. INFORMANT'S NAME (Type/Print)  196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Jean McFeely  8213 Robin Hood Ct Towson, Maryland 21204											
	20s METHOD OF DISPOSITION	200										
	206. PLACE AND DATE OF DISPOSITION   DATE   206. LOCATION — City or Town, State   LOTTAINE Park Cemetery   4/5   Baltimore Mary											
	22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Road Baltimore Maryland 21212											
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Betw.  IMMEDIATE CAUSE (Finel diseases or condition resulting in deeth)  DUE TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING											
SERTIFI												
EDICAL	PART ii. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED?  1 VES 2 NO OF											
Σ									1 TYES 2 NO			
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PL	ACE OF DEATH (Ch	eck only one)						
PHYS	1 YES 2 NO  27. MANNER OF DEATH	1 ☐ inpatient 2 ☐ ER/Outp  26e. DATE OF INJURY	28b. TIM	4 Nursing Hom E OF 28c. INJ	e 5 🗆 Residence			JRY OCCURED				
D BY F	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be	(Month, Day, Year)  28e. PLACE OF INJURY	— At home, farm, a	M 1 🗆 1	RK? 'ES 2 NO	28f. LOCATION	SCRIBE HOW INJURY OCCURED  CATION (Street and Number or Rural Route Number,					
ш	4 Homicide determined	building, etc. (Spec				City or Tov	vn, State)					
COMPLET	29s. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lims, date end place, end due to the cause(s) end manner se stated.  2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the lims, date and place, and due to the cause(s) and manner as stated.											
TO BE	296. SIGNATURE AND TITLE OF CENTIFIES	- Klos	ce		29c. LICENSE NUI	MBER	25	ed. DATE SIGNE	(Month, Day, Year)			
	30. NAME AND ADDRESS OF PERSON WH	HOSP	1 TA C	Print)								
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE Rando R		· · · · · · · · · · · · · · · · · · ·							
	HAK no laan	The second design	- Maritan						DUMM 16 Day 100			

		1 - STATE REGISTRAR	STATE OF I	MARYL	LAND / DEPAI CERTIF	ICAT	T OF H	DEAT	AND N Th	MENTAL HYGIEN REG. NO.	E		5 0 5 7	
		1. DECEDENT'S NAME (First, Middle, L			10111100					2. DATE OF DEATH DATE DO		YEAR	. TIME OF OEATH	
		CLIFFIE 4. SOCIAL SECURITY NUMBER	S .	6 AGE	JOHNSO (In yrs. lest birthday)	IF UNDE	D 1 VEAR	IF UNDER	24 1000	APRIL 2,	199	3	1:04A M	
		214 20 3774	1 🗆 M 25554F	1	5 YRS.	MONTHS	DAYS	HOURS	MIN.	1/11/19	18	a. BIRTHPLACE (State of Country)  Va.		
should		9e. FACILITY NAME (If not institution,	give street and number)	street and number) 9b. CITY, TO					ON OF DE		NTY OF DEA			
2,3	BY FUNERAL DIRECTOR	THE JOHNS HO	PKINS HOSP	ITAL		В	ALTI	MORE	Υ	BALTIMORE CITY				
ages 1,		10a. STATE 10b. CO			10c. Cl	ION				1	Od. INSIDE CITY			
permit. Pages		Md .		Ba			timo					1	LIMITS?	
. TS		1027 N. Cathe	edral St.				10f	212			l -	USA	AT COUNTRY?	
215-0020 attending physician. se as the burial-transit		11. MARITAL STATUS 1 Never Married 2 Merried 2 Wildowed 4 Divorced	FORCES?	12. WAS DECEDENT EVER IN U.S. ARM FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES			If yes, sp	ENOENT O	n, Mexicar	IC ORIGIN? (Specify Yea n, Puerto Rican, etc.)	or No—		- American Indian, White, etc. ack	
21 affe	ETED	15. OECEDENT'S (Specify only highest of			16a. OECEDENT'S (Give kind of	work done			ig .	16b. KIND OF BUS	INESS/INC	DUSTRY		
AND 21 he hospital or detached for u	COMPLE	Elementary/Secondary (0-12)	College (1-4 or 5	+)	Beaut		an			COSMET	OLOG	Y		
YLA by the be deti	ш	17. FATHER'S NAME (First, Middle, Last Rev. John D.					nie	B. More						
MA retain 5 sho notifi	TO B	190. INFORMANT'S NAME (Type/Print) Millicent A.	Walker							oute Number, City or Town		State, Zip Code)		
BALTIMORE, I er death. Page 6 may be the funeral director, page val.		20a. METHOD OF DISPOSITION  1 Suriel 2 Cremation 3 1  4 Donation 5 Other (Specify)	Removal from State								CATION —	- City or Town, State		
BALTIMO after death. Page 6 by the funeral directe moval.		21. SIGNATURE OF FUNERAL SERVICE	E LICENSEE				NAME AN	D ADDRES	SS OF FAC			, Ha	•	
BALTIN  BALTIN  ter death. Pag  the funeral di  wal.		> James	a. Mor	ton		J				rton & So				
aft aft		23. PART /. Enter the diseasea,	or complications the	t ceuse	d the death. Do	not enter	the mo	de of dyl	ng, such	ens St. ]	retory arr	rest,	Md21217 Approximate	
		IMMEDIATE CAUSE (Finel disease or condition	, , , , , , , , , , , ,	1	- 4	d							Interval Between Onset and Death	
of, dithin lifetely remati		resulting in death)	e. OUF TO	O COR AS	A CONSEQUENCE O	411	14/0						25 Min	
ed al.	z	Coronay antry de										1200		
OA 68 be execut sician and or nor to buri	ATIO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING										139/3		
phys ne p	FIC	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):											Sypans	
T E S = 0	ERTIFICATION	resulting in death) LAST d. D. Africulty to when from Variation											5 Monte	
1 - P = 1	O	PART II. Other significent condi	itions contributing to	deeth b	out not resulting	in the ur	derlying	ceuse g	iven in F	Part I. 24a. WAS AN	AUTOPSY	24b. W	ERE AUTOPSY FINDINGS	
and and the Car	DICAL									PERFOR		C	MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?	
w requires that been signed to pt. of Health and shows any	MED												YES 2 NO	
De bas	AN:	25. WAS CASE REFERRED TO MEDICA	. 1				20 04	ACE OF O	FATU (OL.	ck only one)				
SICIAN: The certificate the State 1, or Item	SICI	EXAMINER?	HOSPITAL:	ER/Outs	patient 3 DOA	OTHER	R:			3 Other (Specify)				
A with the C	ву РНУ	27. MANNER OF DEATH  Netural 5 Pending  Accident Investigati	26a. DATE OF (Month, D		28b. Till IN.	- 7	28c. INJU	JRY AT		28d. DESCRIBE HOW IN	JURY OCC	CURED		
OR ATTENDING DIRECTOR: After hours after death tem 28 is mai	입	3 Suicide 8 Could not determine	Dullding.	F INJURY etc. (Spe	f — Af home, ferm, city)	streel, faci	ory, office			261. LOCATION (Street a City or Town, State)	nd Number	or Rural Roul	le Number,	
B B B B	MPLET	29e. CERTIFIER (Check only	HYSICIAN: To the best of	my know	rledge, death occurr	ed at the t	lme, date	and place,	and dua 1	o the ceuse(a) and men	ner ea atat	ed.		
HOSPITAL FUNERAL WITHIN 72	CON		WINER: On the besis of a	xaminatio	n and/or investigation	on, in my o	pinion, de	eth occur	ed at the t	ime, date and place, and	due to th	e cause(a) ar	nd manner as stated.	
TO THE HOSPITAL TO THE FUNERAL Be filed within 72 IMPORTANT: If	TO BE	296. BIGMATURE AND TITLE OF CENT	4//					29c. LICE	NSE NUM	761	29d. DATE	E SIGNEO (M	onth, Day, Year)	
2	-	THE JOHNS HOPKINS HOSPITAL 600N.WOLFE STREET BALTIMORE MD. 21287												
		31. DATE FILED (Month, Day, Year) APR 06 1993	32. REGISTRA	R'S SIGN	ATURE									
- ·				-										



IMPORTANT. If Item 28 is married, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

NG PHTSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. TO THE HOSPITAL DE TO THE FUNERAL DIPER DE filed within 72

	blh												
	FOR 1 - STATE REGISTRAR	STATE OF MA	RYLAND /	DEPARTM ERTIFIC	IENT OF I	HEALTH AND	MENTAL HYGIE REG. NO	46	3	0959	8		
	1. DECEDENT'S NAME (First, Middle, Lest)  Vivian (Vibha)		W o h	3.2				DAY	YEAR	3. TIME OF DEAT	н		
		5. SEX 8.	Koh AGE (In yrs. las		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	3 1	993	0232	M		
	Control Deliver Control Section 1	1 🗆 M 2 💢 F	28	YRS. MO	NTHS DAYS	HOURS MIN.	6-25-64	1	8. BIRTH Countr	India	reign		
OR	Shock Trauma					imore	EATH	90.000	MTY OF D	EATH			
ECT	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNTY			I son CITY TO	OWN OR LOCA								
DIRECTOR	MD				timor	11.525				10d. INSIDE CITY LIMITS? 1 YES 2			
	10e. STREET AND NUMBER					t. ZIP COOE		10g. CIT	IZEN OF W	VHAT COUNTRY?	NO		
FUNERAL	607 Park Ave.					21201		Inc	dia				
В	11. MARITAL STATUS 1 \( \)\ Never Married 2 \( \)\ Married 3 \( \)\ Wildowed 4 \( \)\ Divorced	12. WAS DECEDENT ET FORCES? 1   IF YES, GIVE WAR	YES 2	MED	It yes, s		NIC ORIGIN? (Specify Win, Puarto Rican, etc.)		14. RACE Black	American India K, White, atc.	m,		
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12)	TION impleted) College (1-4 or 5 +)	/G/	CEDENT'S USU ive kind of work Do NOT use rei	done during me		16b, KIND OF BU	JSINESS/INI	DUSTRY				
OM	17. FATHER'S NAME (First, Middle, Last)	110.7				18. MOTHER'S NA	ME (First, Middle, Maide	Sumame)					
BE (	Hori Lal Kohli						i Anand						
10	Hori Lal Kohli		5	7 – 11	224th	St./Ba	Aoute Number, City or To	vn, State, Zij	113	64			
	20a. METHOD OF DISPOSITION 1		20b. PLACE A cernetery, crea Metr	MAND DATE OF DI matory or other p	sposition (Nace) Mater	y Inc.		ocation —					
	21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE				ND ADDRESS OF FA							
	* Isril W. March WM C. MARCH F.H./1101 E. NORT												
	23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  a. HEAD INTURIES												
ATION	DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING  DUE TO (OR AS A CONSEQUENCE OF):												
ERTIFICATION	CAUSE (Disease or injury that initiated events resulting in deeth) LAST	DUE TO (OR	AS A CONSEC	DUENCE OF):									
PHYSICIAN: MEDICAL CE	PART II. Other significant conditions of	contributing to dea	nth but not re	esulting in th	ne Underlyin	g cause given in	Part I. 24a. WAS AI PERFO	RMED?	24b.	WERE AUTOPSY FIN AMAILABLE PRIOR T COMPLETION OF COOP DEATH?	AUSE		
AN	25. WAS CASE REFERRED TO MEDICAL				26. PI	ACE OF DEATH (Che	ack only one)						
Sic	EXAMINER?  1X YES 2 NO 1	IOSPITAL;	VOutpatient 3		HER:	e 5 🗆 Residenca							
F	27. MANNER OF DEATH	28a. DATE OF INJE (Month, Day, Y	URY (bar)	286. TIME OF	28c. INJ		28d. DESCRIBE HOW						
BY	1 Netural 5 Pending 2 Accident Investigation		1992	0153	M 1 🗆	YES 2 NO	story w	jumr	v du	from 21	nd ire		
TED	3 Suicide 8 Could not be determined	28e. PLACE OF IN building, etc.	(эреспу)		, factory, offic		281. LOCATION (Street City or Town, State	)					
E	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIA	AN: To the best of my			the time date	and alone and dur	609 Pai			е			
COMPLETED	(Check only one)  2 MEDICAL EXAMINER: (	On the bests of exami	ination and/or in	nvestigation, in	my opinion, d	eath occured at the	to the cause(s) and ma time, data and place, a	nner as stat nd due to th	led, le cause(s)	and manner as ste	ated.		
BE C	296 SIGNATURE AND TITLE OF CERTIFIER	III L	1			29c. LICENSE NUM				(Month, Day, Year)			
TO B	30. NAME AND ADDRESS OF PERSON WHO C	W/	M			O.C.M	I.E.	•	04	03 1993	3		

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

pe. REGISTRAR'S SIGNATURE

1993

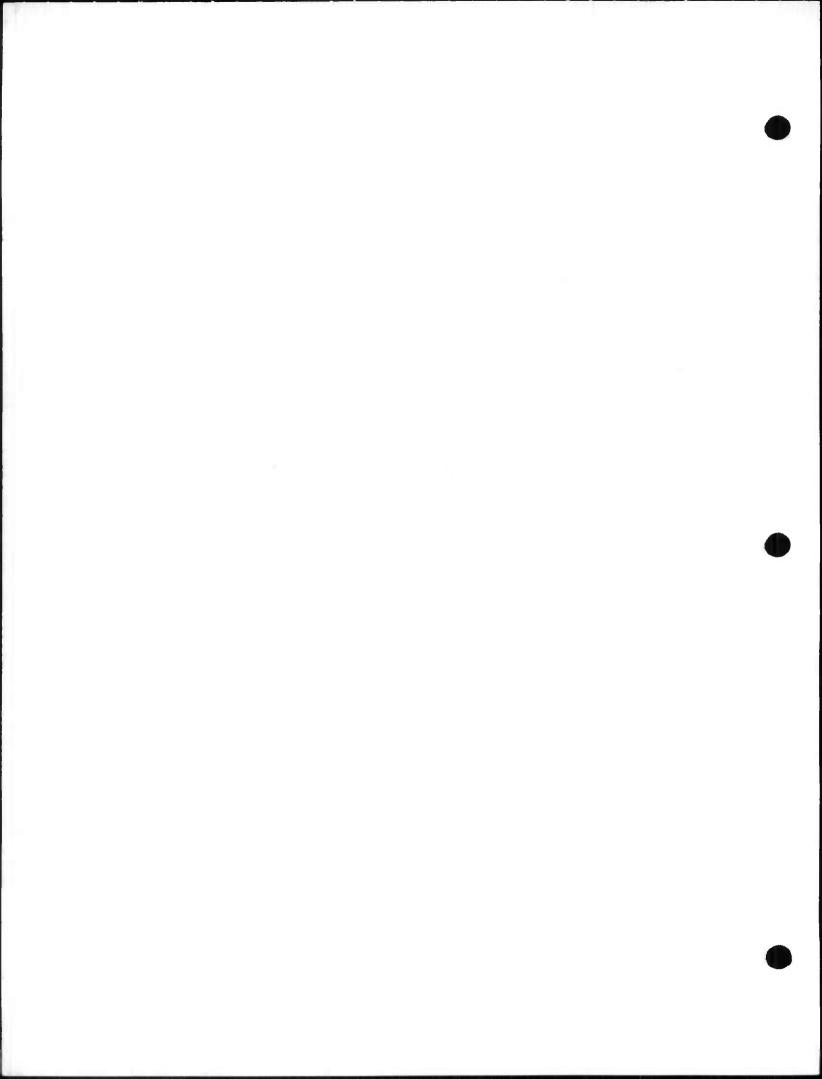
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Street, Baltimore,

DHMH-18 Rev 1/89

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Maryland



BALTIMORE, MARYLAND 2/215-0020

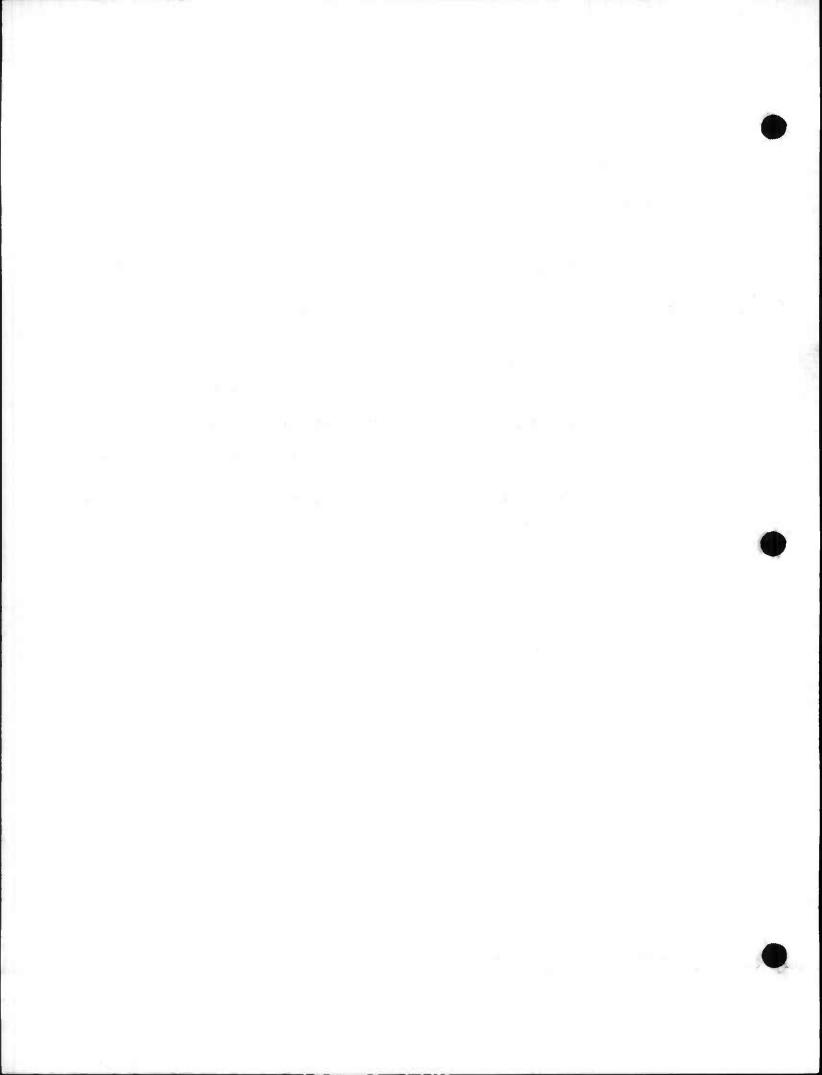
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OING OING	E FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the furner director, area 5 though be treated to be a first of the filled in by the furner of the filled by the filled in by the furner of the filled by t	d within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.	OTANT if them 28 is marked on them 22 shows one interest or other tenentally awant the marked avantages and the contract of th
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	1 - FOR STATE REGISTRAR		STATE OF 1	MARYLAND C	DEPART	MENT OF		MENTAL HYGIEN REG. NO		93	0959	
	1. DECEDENT'S NAME (FI	huni	i (FR.	LDA KHAF			6	2. DATE OF DEATH	AY	YEAR 9 3	3. TIME OF DEATH 5:30/	
	4. SOCIAL SECURITY NU 219-35-2		5. SEX 1  M 2  F	8. AGE (In yrs. In		IF UNDER 1 YEAR MONTHS DAYS		7. DATE OF BIRTH (Month, Day, Year) MARCH 1, 1922			PLACE (State or Foreign) RUSSIA	
OR	94. FACILITY NAME (# 170	OSPITAL				I DR LOCATION OF D	9c. COUR	NTY OF DE	EATH			
DIRECTOR	RESIDENCE OF D	10b. COUNT				TOWN OR LOCALTIMO	ATION				10d. INSIDE CITY LIMITS?	
FUNERAL	100. STREET AND NUMBER 7920 SCC		VEL RD.			11	of. ZIP CODE 21208		10g. CITI		1 YES 2 X NO	
₽	11 (1)	1 Never Married 2 Married FORCES? 1 YES 2 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES					RMED  13. WAS DECENDENT DF HISPANIC DRIGIN? (Specify Yes or N If yes, specify Cuben, Mexican, Puerto Rican, etc.)  1  YES 2  O Specify:					
COMPLETED		ECEDENT'S EDUI only highest grade (0-12)		(0	ECEDENT'S U Give kind of wo le. Do NOT use	SUAL OCCUPAT ork done during m retired.)	nost of working	166. KIND OF BUS		DUSTRY		
111	17. FATHER'S NAME (First, Middle, Lest) ABRAM KHARKHORIN  18. MOTHER'S NAME (First, Middle, Meiden Surname) SOPHIA BELSKAYA											
TO B	19e. INFORMANT'S NAME (TyperPrint)  MR LEONID FRAIMAN  19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  4125 HILL DRIVE APT 106, BLDG 13, UTICA, MI 48317  20e. METHOD OF DISPOSITION  20b. PLACE AND DATE DISPOSITION (Name of State)  20b. PLACE AND DATE DISPOSITION (Name of State)  20c. LOCATION — City or Town, State  20c. LOCATION — City or Town, State  20c. LOCATION — City or Town, State  20c. DAT DIMODE: MD											
	Committee of biol of	ITION		20b. PLACE	ANDDATEDE	DISPOSITION //	Verne of	DATE 20c. LO	CATION -	City or Tow	yn. State	
	A Burial 2 Crema 4 Donation 5 Oth 21. SIGNATURE OF THE	ner (Specify)		20b. PLACE	EAND DATE OF ENGTON	22. NAME A	ZUK AMUNC	4-5-93 BA		OŘE,	MD	
	4 Donation 5 Oth	diseases, or o	complications the	t caused the d	eath. Do no	22. NAME A 601801 t enter the m	ZUK AMUNC AND ADDRESS OF F/ LEVINS REISTERS	0 4-5-93 BA	ALTIMO	OŘE, ,MD 2	MD 21215 Approximate Interval Betw	
IFICATION	23. PART I. Enter the shock, or IMMEDIATE CAUSE (I disease or condition	diseases, or of heart failure.  Final Hitions, redicte Tyling lighty	a. DUE TO	nt caused the de	eath. Do no	22. NAME A 601801 t enter the m	ZUK AMUNC AND ADDRESS OF F/ LEVINS REISTERS	0 4-5-93 BA NGILITY N. BROS DWN RD. BA	ALTIMO	OŘE, ,MD 2	MD 21215 Approximate Interval Betw	
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MEDICAL CERTIFICATION	23. PART I. Enter the shock, or IMMEDIATE CAUSE (I disease or condition resulting in death)  Sequentially list condif any, leading to immicause. Enter UNDERI CAUSE (Disease Dr in that initiated events	diseases, or of heart failure.  Hitions, heddate ying along the same and the same a	a. DUE TO C. DUE TO d.	it caused the de ise on aach ilni (DR AS A CONSE	EDUENCE OF):	22. NAME A 60180 t enter the m	ZUK AMUNC AND ADDRESS OF FI LEVINS REISTERS COde of dying, suc	0 4-5-93 BA NCILITY  NWN RBOS BA sh as cardiac or reapi	ALTIMO	ORE, ,MD 2	Approximate Interval Betwoonset and D	
SICIAN: MEDICAL CERTIFICATION	23. PART I. Enter the shock, or iMMEDIATE CAUSE (I disease or condition resulting in death)  Sequentially list condif any, leading to imm cause. Enter UNDERL CAUSE (Disease or in that initiated events resulting in death)  PART II. Other significations of the standard of the significant of the sign	diseases, or cheart failure. Final Hitions, hediate ying signly as T	a. DUE TO b. DUE TO d. DUE TO d. MOSPITAL: 1/2 Inpetient 2	to caused the desire on each line (DR AS A CONSE) (DR AS A CONSE)  (DR AS A CONSE)  death but not a	eath. Do note that the second	tenter the management of the underlying the underly	ZUK AMUNC AND ADDRESS OF F/I LETSTERS TO THE STATE OF THE	Part I. 24a. WAS AN PERFOR	ALTIMO	ORE, ,MD 2	Approximate Interval Betwoonset and D	
D BY PHYSICIAN: MEDICAL CERTIFICATION	23. PART I. Enter the sheck, or IMMEDIATE CAUSE (I disease or condition resulting in death)  Sequentially list condition resulting in death)  Sequentially list condition resulting in death)  CAUSE (Disease or in that initiated events resulting in death) LA  PART II. Other signification of the condition of the c	diseases, or content of the second of the se	B. DUE TO  B. DUE TO  C. DUE TO  DUE T	to caused the desire on each line (DR AS A CONSE) (DR AS A CONSE) (DR AS A CONSE)  death but not ()  ER/Outpatient 3  INJURY	eath. Do note.  EDUENCE OF):  EDUENCE OF):  Teaulting in  3 □ DOA 4  28b. TIME of insurance of the content of t	the underlying 28. POTHER:	ZUK AMUNC AND ADDRESS OF FI LEVINS REISTERS TO THE STATE OF THE STATE	Part I. 24a. WAS AN PERFOR	ALTIMO ALTOPSY INCOME  AUTOPSY INCOME  AUTOPSY IN HO  NJURY OCC	ORE, ,MD 2 eat, 24b. 1	Approximate Interval Betwood Donest and Donest and Donest and Donest and Donest and Donest and Donest and Donest and Donest and Donest and Donest and Donest and Donest and Donest and Donest Approximate D	
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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year) (APR = 6 1993)



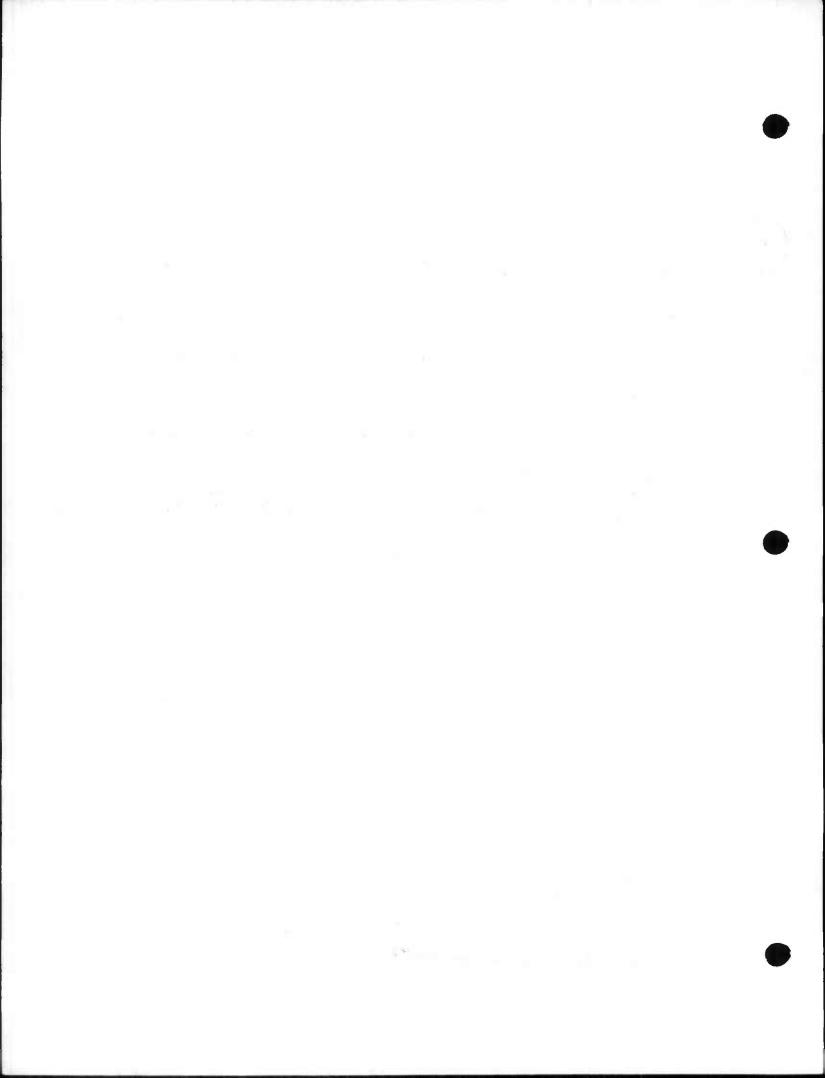
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DIVISION OF VITAL RECORDS,	
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 43 essie 30 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yes last hirthdu IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign DAYS 220-54-3353 1 M 2 XF 86 5/1/1906 MARYLAND 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR BALTIMORE SINAI HOSPITAL RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY BALTIMORE MARYLAND 1 X YES 2 | NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21215 3618 FORDS LA., APT. D 24 hours after death. Page 6 may be retained by the hospital or attending physician if filled in by the funeral director, page 5 should be detached for use as the burial-train 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 NO Never Married 2 Married ВҰ 3 Widowed 4 Divorced WHITE use as the COMPLETED 15. DECEDENT'S EDUCATION seclly only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY during most of working (Give kind of work done life. Do NOT use retired.) 12 College (1-4 or 5+) HOUSEWIFE AT HOME 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Suman JOSEPH SILVERMAN ETELSON ANNA BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 JEROME KOBERNICK 8501 TOPPING RD. BALTO., MD 21208 pe 20a. METHOD OF DISPOSITION

AND Burlal 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must 4 ☐ Donation 6 ☐ Other (Specify) 4/1/93 BNAI ISRAEL BALTIMORE, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 3 6010 REISTERTOWN RD 21215 or removal. BALTO. the medical 23. PART Intended diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, attending physician and completely filled in by Approximate ock or heart fellure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final **Onset and Death** cremation. disease or condition within resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF) executed prior to burial, emic traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate death certificate be ai cause. Enter UNDERLYING CAUSE (Disease or injury or other Mental Hygiene DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in deeth) LAST injury, certificate has been signed by the h the State Dept. of Health and Mer PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. law requires that the MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE PERFORMED shows any 1 TYES 2 OF DEATH? 1 TES 2 NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL item ; The 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 TES 2 NO HOSPITAL OR ATTENDING PHYSICIAN: etient 2 ER/Outpetient 3 DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) 10 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED with is marked, this 1 Netural 5 Pending BY 1 YES 2 NO THE FUNERAL DIRECTOR: After filed within 72 hours after death 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 28 If item 29a, CERTIFIER 1 A CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. MPORTANT: 29d. DATE SIGNED (Month, Day, Year)

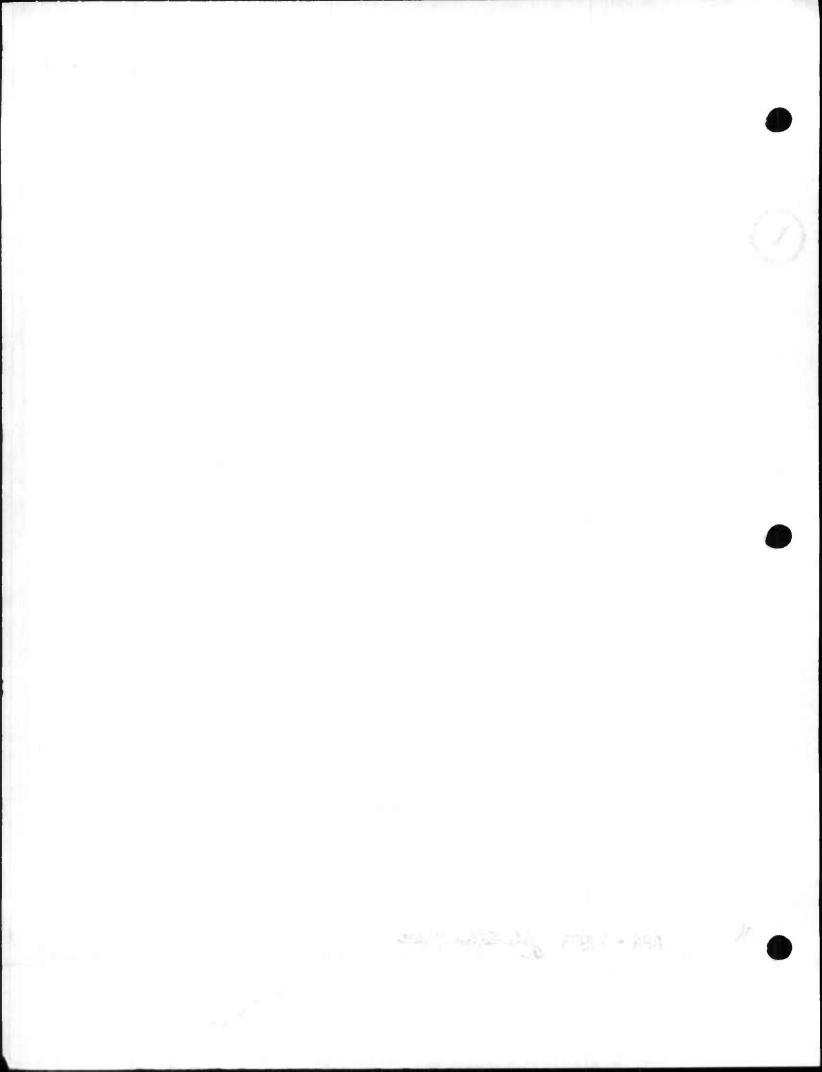
3/36/93 296. SIGNATURE AND TITLE OF CER 29c. LICENSE NUMBER 出 BE M.D 2 2 3 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

DHMH-16 Rev 1/89



	1. DECEDENT'S NAME (First, Middle, Last)			FICATE OF		2. DATE OF DEATH	DAY	year 3. TIME OF DEATH				
	Helen	_	ein			04/02/1	993					
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	19.4		8. BIRTHPLACE (State or Foreign Country)				
	218 40 9399	1 M 2 XF	83 YRS.		10.5310	01/26/1	910	Maryland				
æ	9a. FACILITY NAME (If not institution, give				OR LOCATION OF		9c. COUN	TTY OF DEATH				
6	1205 W. 42n	<u>d Stree</u>	t		Baltim	ore	Ba:	lto. City				
DIRECTOR	10e. STATE 10b. COUNT	TY	10c. CI	10c. CITY, TOWN OR LOCATION 10d. IN:								
	Maryland		E	altimo:	re			LIMITS?				
₹ J	10e. STREET AND NUMBER	•	***************************************		H. ZIP CODE		10g. CITIZ	ZEN OF WHAT COUNTRY?				
Ä	1205 W. 42					1211		J.S.A.				
COMPLETED BY FUNERAL	11. MARITAL STATUS  1 Never Married 2 Married	FORCES?	NT EVER IN U.S. ARMED	If yes, sp	secify Cuban, Mex	PANIC ORIGIN? (Specify Y	fes or No-	14. RACE — American Indian, Black, White, etc.				
	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE	WAR OR DATES	1 TYES	S 2XXNO Spe	nalfy:		Specify:				
	15. DECEDENT'S EDU	JCATION		S USUAL OCCUPATI		16b, KIND OF B	USINESS/IND	White				
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5	We Do NOT	work done during mo use retired.)	ost of working							
M M	11	2	Home	maker								
COM	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S	NAME (First, Middle, Maide	on Sumame)					
BE	Joseph	Roy D	urkan			llie Vir						
2	H. Eileen	Vorn				al Route Number, City or To						
		Kern	303		en Road			aryland 2128				
	20e METHOD OF DISPOSITION  1 A Burial 2 Compation 3 Rem 4 Donation 5 Qther (Specify)	noval from Stata	20b. PLACE AND DATE camelery, crematory or	of DISPOSITION (Na	ame of	DATE 20c. L	OCATION — C	Maryland				
	21. SIGNATURE OF FUNERAL SERVICE LA	CENSEE //	- Meadowri	age Men	NO ADDRESS OF	PK 4/A DO	rsey,	Maryland				
	Burgee-Henss Funeral Home 3631 Falls Road, Balto. Mo											
- 1	3631 Falls Road, Balto. M											
	snock, or neen failure.	complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, List only one cause on each line.  Approximate interval Between Onset and De										
	iMMEDIATE CAUSE (Final disease or condition	Choix Obstructure Pulm Di										
- 1	resulting in death)	DUE TO	O (OR AS A CONSEQUENCE O		7,44	•	- /	12				
z		h										
은	Sequentially list conditions, If any, leading to immediate	DUE TO	OR AS A CONSEQUENCE O	)F):								
2	CAUSE (Disease or injury	c										
	thet initiated events resulting in death) LAST	DUE TO	O (OR AS A CONSEQUENCE O	)F):								
CERTIFICATION		d										
	PART II. Other significant condition	ns contributing to	death but not resulting	in the underlyin	g ceuse given	In Part I. 24a. WAS A	N AUTOPSY	24b. WERE AUTOPSY FINDING				
DICAL						1 □ YES	2 NO	AVAILABLE PRIOR TO COMPLETION OF CAUSE				
ME								OF DEATH?				
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. Pt OTHER:	LACE OF DEATH (	Check only one)						
PHYSICIAN:	1 YES 2 NO		☐ ER/Outpatient 3 ☐ DOA	4 - Nursing Hom		e 6 🗆 Other (Specify)						
	1 Natural 5 Pending	26e. DATE Of (Month, L		JURY WO	FURY AT DRK?	26d. DESCRIBE HOW	INJURY OCC	URED				
BY	2 Accident Investigation 3 Suicide Could and by	28a, PLACE C	OF INJURY — Al home, ferm,		YES 2 NO							
9	4 Homicide determined	building	, alc. (Specify)	atteet, factory, offic	•	26f. LOCATION (Street City or Town, State	t and Number ( e)	or Rural Route Number,				
COMPLET	29a. CERTIFIER CERTIFYING PHYS	ICIAN: To the heart										
MP	(Check only one) 2 MEDICAL EXAMINE	R: On the beals of a	f my knowledge, death occurr examination and/or investigation	ed at the time, date	and place, and d	ue to the cause(a) and m	anner ea state	d. cause(a) and manner as stated.				
	29b. SIGNATURE AND TITLE OF CERTIFIE		a l	, or my opnison, u				1				
BE	merin ?	9h.	Ven M		29c. LICENSE N	CL2	29d. DATE	SIGNED (Morth, Day, Year)				
2	30. NAME AND ADDRESS OF PURSON WH	O COMPLETED CALL	SE OF DEATH (ITEM 27) /3	Print)		, , , , ,	1 4	17192				
- 8			re (11 Em £1) [7/D6									

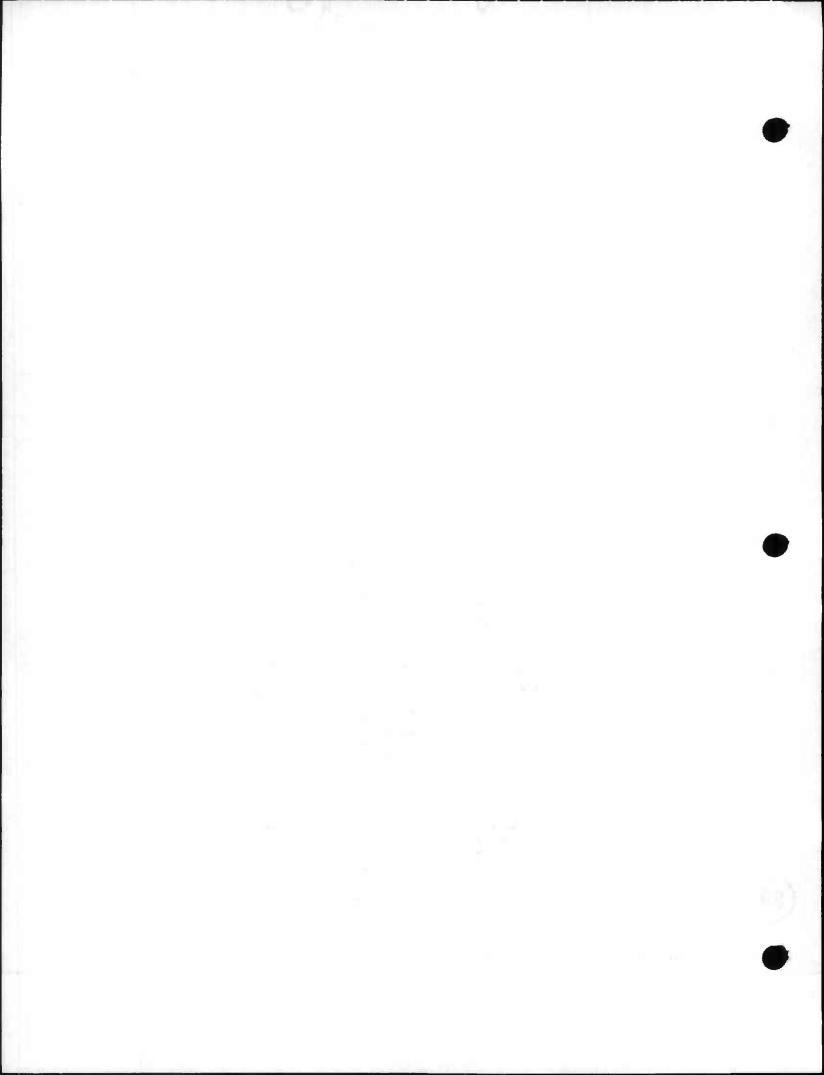
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BALTIMORE, MARYLAND 21215-0020

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	FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H		ENTAL HYGIEN REG. NO.	E	3 0 3 0 0 1			
1	1. DECEDENT'S NAME (First, Middle, Last)	Koch Ka	rl Geo:	rge Koc	h	DATE OF DEATH MONTH DA	7	3. TIME OF DEATH  3. TIME OF DEATH			
8	212 12 2201	5. SEX 6. AGE (	(In yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. 7	Month, Pay Year 8	1	BIRTHPLACE (State or Foreign Country)			
TOR	9s. FACILITY NAME (If not institution, give stre Anne ARundel Med	,	er	Annapo	Н	Anne ARundel					
DIRECTOR	RESIDENCE OF DECEDENT  100. STATE  MD  Anne	ARundel		napolis		10d. INSIDE CITY LIMITS? % X YES: 2   NO					
FUNERAL	100. STREET AND NUMBER 11 Constitution	n Ave		101.		10g. CITIZEI USA	N OF WHAT COUNTRY?				
B	11. MARITAL STATUS 1 Never Married Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 XYES IF YES, GIVE WAR OR D. WWII	2 NO		ORIGIN? (Specify Yes Puerto Rican, etc.)	s or No- 14. RACE — American Indian, Black, White, etc. Specify: White					
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)	TION ompleted) Coflege (1-4 or 5+)	16a. DECEDENT'S (Give kind of the life. Do NOT us	USUAL OCCUPATIO work done during mos e retired.)	N st of working	16b. KIND OF BUS	INESS/INDUS	THY			
M M	9	9	Chief	Comm.	Steward	U.S	. Na	vy			
00	17. FATHER'S NAME (First, Middle, Last)					(First, Middle, Malden	Sumame)				
BE	Charles George 19a. INFORMANT'S NAME (Type/Print)	Koch				a Wentz					
TO BE COM	Katherine P. Ke	ach			tion Ave			, MD 21401			
	20a. METHOD OF DISPOSITION	206	PLACE AND DATE	OF DISPOSITION (Nat				y or Town, State			
	1 💢 Burial 2 🗆 Cremation 3 🗆 Remov 4 🗆 Donation 5 🗆 Other (Specify)		netery, crematory or o	<sup>ther place)</sup> st Ceme	terv	Ann	apol:	is,MD 21401			
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE		Harde	sty Fune	ITY					
	Momps 19	talesty		12 Ri	dgely A	ve. Anna	polis	s,MD 21401			
CERTIFICATION	23. PART I. Enter the diseases, or complications that clused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Due to (or as a consequence of):										
MEDICAL	PART II. Other algnificant conditions  Competition	contributing to death b		n the underlying	j couse given in Pa	ort i. 24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 \( \sum \) YES 2 \( \sum \) NO			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			ACE OF DEATH (Check	only one)		1			
YSI	1 VES 2 KINO	I Inpetient 2 I ER/Outp			5 Residence 6	Other (Specify)					
	27. MANNER OF DEATH  1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	URY WO	RK?	ed. DESCRIBE HOW II	NJURY OCCUP	RED			
TED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, ferm, s		/ES 2 NO 2	81. LOCATION (Street a City or Town, State)	and Number or	Rural Route Number,			
COMPLETED		AN: To the best of my know On the basis of examination						:ause(a) and manner as stated.			
TO BE	296. SIGNATURE AND TITLE OF CENTRED  30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	M O	Print	D3 3 6	S Y	29d. DATE S	IGNED (Month, pay, Year)			
	John P. Ser	132. BEGISTRAR'S SIGN	180 Aa	miral	Cochro	re pr.	, An	ngolis, mo			
	APR 06 1993	a Davidson-Ran	della								



FUNDING PHYSICIAN: The law requires that the death certificate be executed within a first death. Page 6 may be retained by the hospital or attending physician.

FUNDING TOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be to sain with the State Dept. of Health and Mental Hydrene prior to burial, cremation, or removal.

-	FOR STATE REGISTRAR	

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

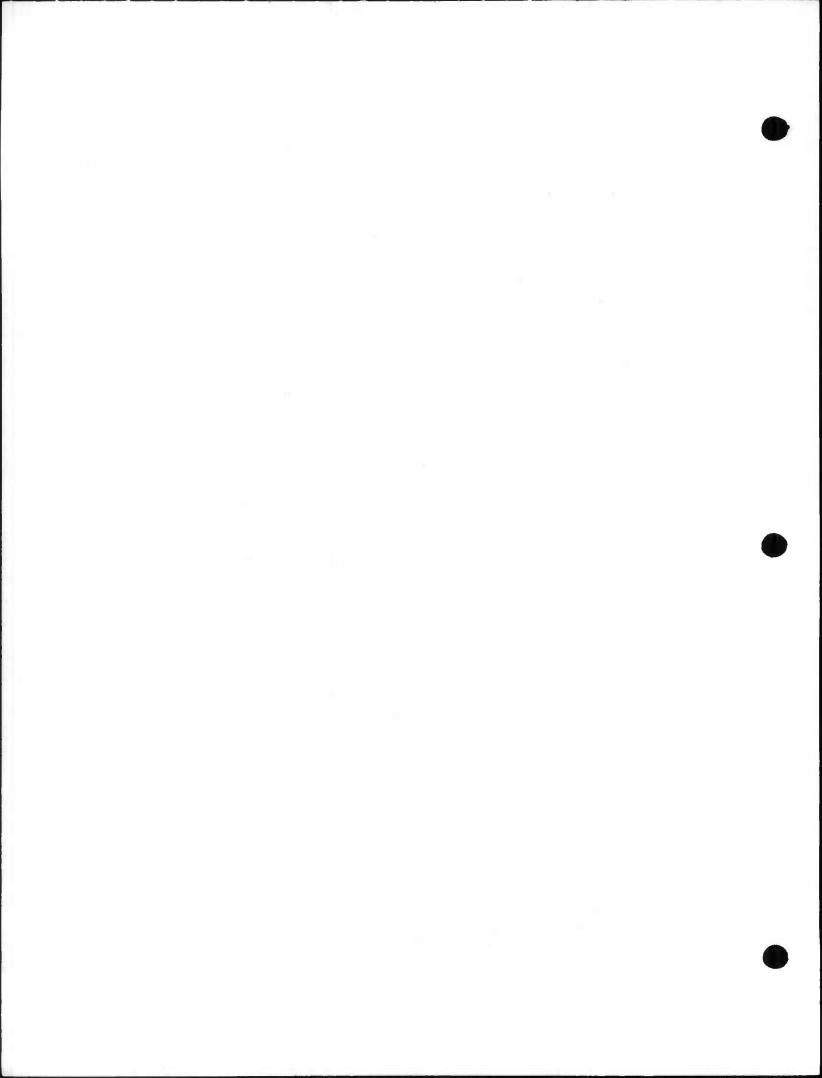
	1. DECEDENT'S NAME (First, Middle, Last)	*							2. DATE OF DE	ATH	y .	1	3. TIME OF OEATH
	EVELYN MILDRED LI	TZ							MONTH	DA	Y (	YEAR	6:50p H
	4. SOCIAL SECURITY HOUBER	5. SEX 8. AGE (in yrs. less		st birthday)	IF UNDER		IF UNDER		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTH		HPLACE (State or Foreign
	218-07-1645	1 🗆 M 2 🕡	85	YRS.	MONTHS	DAYS	HOURS	MIN.	07270		7		INIA
	9a. FACILITY NAME (If not institution, give to	street and number)			9b. CITY	, TOWN	OR LOCATI	ON OF DE	EATH 9c. COUNTY OF DEATH				
e l	MARYLAND MANOR NU	RSING HO	ME C	-5	GL	EN E	BURNI	E	710	9.	ANNE	ARU	INDEL
اق	RESIDENCE OF DECEDENT  10a, STATE  10b, COUNT	v		1400 CD	ry, town	OB LOCA	TION						10d. INSIDE CITY
DIRECTOR		ARUNDEL			N BU				LIMITS?				LIMITS?
	MARYLAND ANNE  100. STREET AND NUMBER	AKUNDEL		GLE	N DU		1. ZIP COD	E	10g. CITIZEN OF V				
FUNERAL	7575 EAST HOWARD	DUZU					1061						
3	11. MARITAL STATUS	IT EVER IN U.S. A			WAS DEC	CENDENT (	OF HISPAN	IIC ORIGIN? (Spe	cify Yes	U.S.	14. RAC	E — American Indian,	
	1 Never Married 2 Married		YES 2 X	NO			ecify Cubi		n, Puarto Rican,	etc.)		Spec	
ВУ	3 Wildowed 4 Olvorced												WHITE
	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  12 YEARS  15. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  12 YEARS  15. KIND OF BUSING (Give kind of work done during most of working life. Do NOT use retired.)  16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  17. FATHER'S NAME (First, Middle, Last)  18. MOTHER'S NAME (First, Middle, Maiden STANDER)  18. MOTHER'S NAME (First, Middle, Maiden STANDER)  19. KIND OF BUSING (Give kind of work done during most of working life. Do NOT use retired.)									OF BUS	INESS/IN	DUSTRY	
빌										CHIDI	/T O TO	TNIC	
M	12 YEARS -	2 YEARS   ST							ME (First, Middle,			ICE	INC.
	UNKNOWN			HAL	L			NOWN	me (r rot, micons,	margon (	Gurramey		
BE	19a. INFORMANT'S NAME (Type/Print)		1	9b. MAILIN	G ADDRES	S (Street	and Numbe	r or Rural I	Poute Number, Cit	y or Town	n, State, Z	ip Code)	
2	GEORGE H. LITZ, I	II		512 0	LD B	ACHM	IAN V	ALLE	Y ROAD	WES	TMIN	STER	R, MD 21157
	20a. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Ren	noval from State	20b. PLACE	OF OISPO	SITION (N	ame of ce	metery, cre	matory or		20c. LO	CATION -	- City or T	Town, Stata
	4 Donation 5 Other (Specify)					matory 4-3-93 BALTIMORE, MARYLAND							
	21. SIGNATURE OF PUNERAL SERVICE LI	CENSEE		22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME									
	· WAN NEW	on Lu	mbr	_	_						BUF	NIE,	MD 21061
	23. PART / Enter the diseases, or	complications the	at caused the d	leath. Do	not anta	r tha m	oda of dy	/ing, auc	h as cardiac o	or respl	ratory a	rrest,	Approximate
	Interval Between Onset and Death  Interval Between Onset and Death												
	IMMEDIATE CAUSE (Final disease or condition resulting in death)  a. MY 0 CARDIAL INFARCTION												
	resulting in death)  a. ARTERIO — SCLEROTIC CARDIO — VASCULAR  CONTROL OF TO (OR AS A CONSEQUENCE OF):  ARTERIO — SCLEROTIC CARDIO — VASCULAR  CONTROL OF TO (OR AS A CONSEQUENCE OF):											SECULAR	
8	Sequentially list conditions,	b. 11/ OUE TO	LOB ASA CONS	EOHENCE (		ICO	110		Chi	-121	0 -	\( \( \) \( \)	NICENSE
I E	If any, leading to immediata cause. Enter UNDERLYING	CON	UGE	STIVE HEART FAILURE						PE			
[윤]	CAUSE (Disease or Injury that Initiated events	O DUE 70	(OR AS A CONS	EQUENCE (	P(F): (7)	0-	-0		11.40	0			
CERTIFICATION	reaulting in death) LAST	o. CH	-ONL	ILC OPSSTRUCTIVE PULMONA						427			
	PARS ii. Other algoliticant conditie	ns. contributing to	daath but not	reauiting	in the u	nderlyir	na cause	aiven In	Parthi. 24a.	WAS AN	AUTOPS	D45	H-WIRE AUSOPSY FINDINGS
EDICAL	10 LD CE	PERI	20=V	A-SC	WLA	(0)	1/10	ON		PERFOR		1	AVAILABLE PRIOR TO COMPLETION OF CAUSE
	MA-Inp	DF	DRE	200	00	1	1111		743	AER 5	₩ NO		OF DEATH?
Σ.	SPAILE	= NE	MEA	T	^				-				10 10 10 10
SICIAN	25. WAS CASE REFERRED TO MEDICAL		1. 1	11	4	26. F	LACE OF	DEATH (Ch	eck anty anel			_	
Sic	1 YES 2 NO	HOSPITAL:	☐ ER/Outpetient	3 DOA	4 X Hu		me S 🗆 R	lesidence	6 ☐ Other /Spe	olfy)			
РНУ	27. MANNEN OF DEATH	28a. DATE O	F INJURY Day Mear)	286, 70	ME OF		JURY AT		26d. DESCRIBE	E HOW II	NUURY O	CCURED	
ВУБ	1 Metural 5 Pending 2 Accident Investigation	//2555	erthitely.		м		YES 2	□ NO					
	3 Suicide 8 Could not be		OF INJURY — At I	some, ferm,	street, fac	riory, offi	ce		28f. LOCATION City or Tow	(Street a	and Mumb	er or Rumi	Ploute Number
ETE	4 Homicide determined												
19	(Shaon only	SICIAN: To the best of	f my knowledge,	death occu	rred at the	time, dat	a and plac	e, and due	to the cause(s)	and mar	nner as sl	lated.	
COMPLET	one) 2 MEDICAL EXAMIN	ER: On the basis of	examination and/o	r Investigat	lon, In my	opinion,	death occi	ured at the	time, data and p	place, an	d dua to	the cause	(a) and manner as stated.
BE	286. BIGHING AND TITLE OF CERTIFIE	rgh o	Atter	div	ve Pi	hys	29c. LIC	CENSE NU	1416	0	29d. O	HE SIGNE	12193
2	30. NAME AND ADDRESS OF PERSON W	GH M	JSE OF DEATH (IT	EM 27) (TYP	oe, Print)	ZIT	CH	IF	H16#1	WA	4,	BAL	TIMORE,
	31. DATE FILED (Month, Pay, Year)	32. REGISTR	AR'S SIGNATURE	مد الد	1 1	-(1	* 1	1	VI WI	/	-	<u> </u>	MA.212
	APR 06 1993	of which	midon-N	where	•								

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merial Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. TO BE COMPLETED BY FUNERAL DIRECTOR BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760, TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM	MENT OF H	EALTH AND DEATH	MENTAL HYGIE					
N	DECEDENT'S NAME (First, Middle, Last)	Evelyn P. Lo				2. DATE OF DEATH	1993	3. TIME OF DEATN			
				UNDER t YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTN					
	215-22-6981	1 🗆 M 2)(X)(F) 7	O YRS.	HITHS DAYS	HOURS MIN.	(Month, Day, Year) 11-19-1	C	ORTHPLACE (State or Foreign Country)  Md			
	9a. FACILITY NAME (If not institution, give stre 1142 N. Longwoo	od Street	91	Baltin	OPE	EATH	OF DEATN				
	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY		I too CITY Y	OWN OR LOCAT	1011			1.11.12 miles			
	Md		Balti		ION		10d. INSIDE CITY LIMITS?  1 YES 2 NO				
	10e. STREET AND NUMBER	Charat		101	ZIP CODE			OF WHAT COUNTRY?			
	1142 N. Longwood				21216		US	A			
	1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 ☐ YES IF YES, GIVE WAR OR DA	2)(NO	If yes, sp		NIC ORIGIN? (Specify Y an, Puerto Rican, etc.) fy:		RACE — American Indian, Black, White, etc. Specify: Black			
	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)	ATION ompleted) College (1-4 or 5+)	16a, DECEDENT'S USI (Give kind of work life. Do NOT use re	done during mo	N st of working	16b. KIND OF B	JSINESS/INDUSTI	RY			
	12th										
	17. FATHER'S NAME (First, Middle, Last) Chester Jenning	S			18. MOTHER'S NA Maude	AME (First, Middle, Maide	n Sumame)				
	19a, INFORMANT'S NAME (Type/Print)		19b. MAILING AD	DRESS (Street a	nd Number or Rural	Route Number, City or To	wn, State, Zip Code	0)			
	Eather W. Lofton		1142	N. Lon	gwcod St	reet Balt	imore, 1	Md 21216			
	20s, METNOD OF DISPOSITION  1 X Burlel 2 Cremetion 3 Remov  4 Donation 5 Other (Specify)		PLACE AND DATE OF D etery, cremetory or other King Mem			2000	dallstov				
	21. SIGNATURE OF FUNERAL SERVICE LICE			22. NAME AND ADDRESS OF FACILITY							
	23. PART I. Enter the diseases, Dr CD	2 Wans			h F/H We Wabash						
	shock, or heart failure. Li  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in daath) LAST	DUE TO (OR AS A	ch line.			over		Approximate interval Between Onset and Death			
	d.										
	PART II. Other significant conditions	contributing to death bu	- /	he underlying with the liene			RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?  1 YES 2 NO			
	25. WAS CASE REFERRED TO MEDICAL			26. PL	ACE OF DEATH (Ch	eck naty one)					
Ì		HOSPITAL:		THER:		8 Other (Specify)					
1	27. MANNER OF DEATN	28a. DATE OF INJURY	28b. TIME O			28d. DESCRIBE NOW	INJURY OCCURE	D			
ì	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	WO	RK? ES 2 NO						
	3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE OF INJURY building, atc. (Special	At home, larm, stree	it, Inctory, office		28f. LOCATION (Street City or Town, State	and Number or Ru	ural Route Number,			
		AN: To the best of my knowle On the basis of examination						ree(a) and manner as stated,			
	29b. SIGNATURE AND TITLE OF CERTIFIER	2 1	шл		29c. LICENSE NUI	MBER 140	29d. DATE SIG	NED (Month, Day, Year)			
	30. NAME AND ADDRESS OF BERSON WHO	COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, Prin	us to	RINA	P. 14	MA	12021			
	APR 06 1993	12 Sunday S	ndall,	The	- 44 160 -	. sau	7 4	74.0			



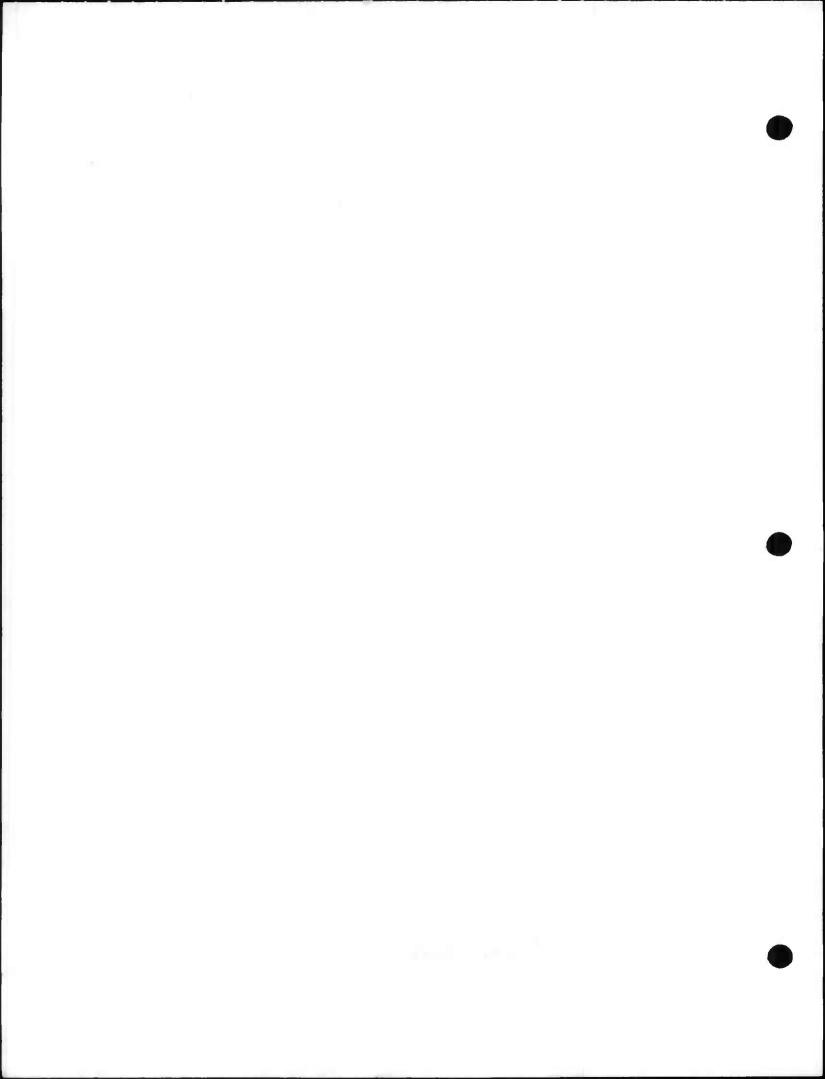
BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2

pilai di attending priyacian.	je 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should		
מו מו מו מו מו מו מו מו מו מו מו מו מו מ	I director, pag	Z HOURS AFTER CHARLIF WITH THE CHARLE DEPT. UT TREATHER MY METER PRIOR TO BEHAVER, CHARLEUSHI, OF THE THOUGH.	APORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
	TO THE FUNE	JE IIIEO WILLIAM	MPORTANI

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	4 OF OFFICE HAVE (CITY				-11111	IOAIL	. 01	DLA	111		REG. NO.			
1 3	1. OECEDENT'S NAME (First,		1	. ~						2. DATE	OF DEATH DA	NY	YEAR 3	3. TIME OF OEATH
	PRATHE		C. LAN							04	0	3	93	830 AM
1	4. SOCIAL SECURITY NUMB		5. SEX	6. AGE (In yrs. las	it birthday)	IF UNDER		IF UNDER		7. DATE (	Day, Year)		8. BIRTHPL Country)	LACE (State or Foreign
	226-14-01	466	1 M 2 F	74	YRS.	MONTHS	DAYS	HOURS	MIN.	0		19	Courtry)	-S. C.
	9a. FACILITY NAME (If not ins	stitution, give st	reet and number)			9b. CITY,	TOWN (	OR LOCATI	ON OF OE		707	9c. COUN	TY OF OEA	ATH
<u>۳</u>	University	1	versity 0			Bath								
DIRECTOR	RESIDENCE OF DEC	EDENT	75/1904				110			_				
<u> </u>	10a, STATE	10b. COUNTY	,		10c. CIT	Y, TOWH O	R LOCAT	TION				-	1	0d. INSIDE CITY
ā	MO				13	alto							١,	LIMITS? YES 2 NO
4	10e. STREET AND NUMBER				1 100	re v. o	101	. ZIP COO	E			10s CITIZ		AT COUNTRY?
3	740 Parl		rue st				- 1	2	_			log. Of the	4 .	S.A
FUNERAL	11. MARITAL STATUS	W 67		T EVER IN U.S. AR		100	-						- 1	
	1 Never Married 2 1	Married	FORCES? 1	YES 2 X	NO NEO	13. \	WAS OEC yes, sp	ecify Cube	OF HISPAN In, Maxican	IC ORIGIN: 1, Puerto R	(Specify Yes	or No-	Black, \	- American Indian, White, atc.
B	3 Widowed 4 Divor		IF YES, GIVE V	AR OR OATES		1	☐ YES	2 NO	Specify.	2			Specify	Black
	44 050													3144
1	(Specify only	highest grade	completed)	16a, DE	CECENT'S	Work done of se retired.)	CUPATIO luring mo	ON est of working	ng	16b.	KINO OF BUS	INESS/INDU	JSTRY	
3	Elementary/Secondary (0-		College (1-4 or 5	)										
Σ		B.A	- 4yrs	50	yen	an								
COMPLETED	17. FATHER'S NAME (First, Mic	ddle, Last)						18. MOTI	HER'S NAM	ME (First, M	iddle, Meiden	Surgame)		
96	Islah	land						Tr	ene	- 4	Ihite.	side		
10	19a. INFORMANT'S NAME (Ty	rpe/Print)	7	191	, MAILING	ADDRESS	(Street a				or, City or Town	, Statu, Zip (	Code)	
F	Jacquetine	E.	Day		3814	o Co	nle	y K	load	l	Balt	7) 1	d	
	20a. METHOD OF DISPOSITIO	ON		20b. PLACE	ANO OATE	OF DISPOSI	ION (Na	_		_	20c, LO	CATION - C	ity or Town	. State
	1   A Buriel 2   Cremetion 3   Removal from State   Cemetary cremetary or other place)													
	4/1 Donatton 5 Other (Specify) Ft Lincoln Cem 17/93 Orenwood, My													
	22. NAME AND AGORESS OF FACILITY  Thank F. H. West													
_	23. PART 1. Enter the draws, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate													
	23. PART 1. Enter the di	eases, Dr c	omplications the	t caused the da	eth. Do i	not enter	tha mo	de of dyl	ing, such	ss cardi	ec or respi	ratory arre	eat,	Approximate
			lst only one cau	ise on each line	•									Interval Between
ı	IMMEDIATE CAUSE (Finel disease or condition resulting in death)  a. CERESOVASCULAR ACCIDENT												Oliset sild Destil	
l	resulting in death)  a. CETCONNASCULATE ACCIDENT  OUE TO (OR AS A CONSEQUENCE OF):													
- 1	OUE TO (OR AS A CONSEQUENCE OF): HY PER TETUS 1 DTV													
CERTIFICATION	Sequentially list conditions,													
A	If any, leading to immed cause. Enter UNDERLYIN			DM		,								i
윤	CAUSE (Disease or Injur	у 🥻 с		(OR AS A CONSEC	DUENCE O	FI:								
E	resulting in death) LAST			TRIPL F		•								i
9		d		I KING F	-119					_				-
	PART II. Other algnificar	nt conditions	contributing to	death but not n	esulting	in the un	derlying	cause g	lven in F	Part I.	24a. WAS AN	AUTOPSY	24b. W	ERE AUTOPSY FINDINGS
EDICAL											PERFOR	-		WAILABLE PRIOR TO OMPLETION OF CAUSE
										- 1	1 TYES 2	NO		F OEATH?
≥	-									- 1			1	☐ YES 2 ☐ NO
Ž.		Address I												
₫ I	25. WAS CASE REFERRED TO EXAMINER?		HOSPITAL:			OTHER		ACE OF D	EATH (Che	ck only one	)			
PHYSICIAN:	1 YES 2 NO		1 Impatient 2	ER/Outpatient 3	□ DOA			e 5 🗆 Ra	sidenca 8	3 🗆 Other	(Specify)			
E	27. MANNER OF DEATH		28a. OATE OF (Month, D		28b. TIM	E OF URY	28c. INJ	URY AT		28d. DE\$0	RIBE HOW I	JURY OCCL	JREO	
<u>M</u>	1 Netural 5 P	ending nveatigation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, 100/		M		ES 2 [	NO					
	2 Cidalda —	Could not be	28e. PLACE O	F INJURY — At ho	me, farm, i	street, facto	ry, office	1		28f. LOCA	TION (Street a	nd Number o	or Rural Rou	te Number.
=		etermined	bullding,	etc. (Specify)					- 1	City or	Town, State)			
3	29a. CERTIFIER	EVINC BUVEIO	MAN. T. at. A			-								
₹			MAN: To the best of											
COMPLETED			C On the basis of a	tamination and/or i	nveatigatio	in, in my op	inlon, de	eath occur	ed at the t	lme, data s	nd place, and	dua to tha	ceuse(a) a	nd manner as stated.
ш	296. SIGNATURE AND TITLE	OF CERTIFIER	000	0					NSE NUMI			29d. DATE	SIGNEO (M	forith, Day, Year)
8	craw	and	MIA					AUI	4176	435 P	18575	<b>&gt;</b> (	1/3/	93
2	30. NAME AND ADORESS OF	PERSON WHO	COMPLETED CAUS	SE OF DEATH (ITEM	<b>4 27)</b> (Ђ/ре,	Print)		-					110	
	Unio a	SF A	MANULA	Cov.	Dem	07	- ~	EU	NO L	vay	1			
					-									
	APR 06 19	993	Julia Davi	R'S SIGNATURE	AL.									
			/	3										



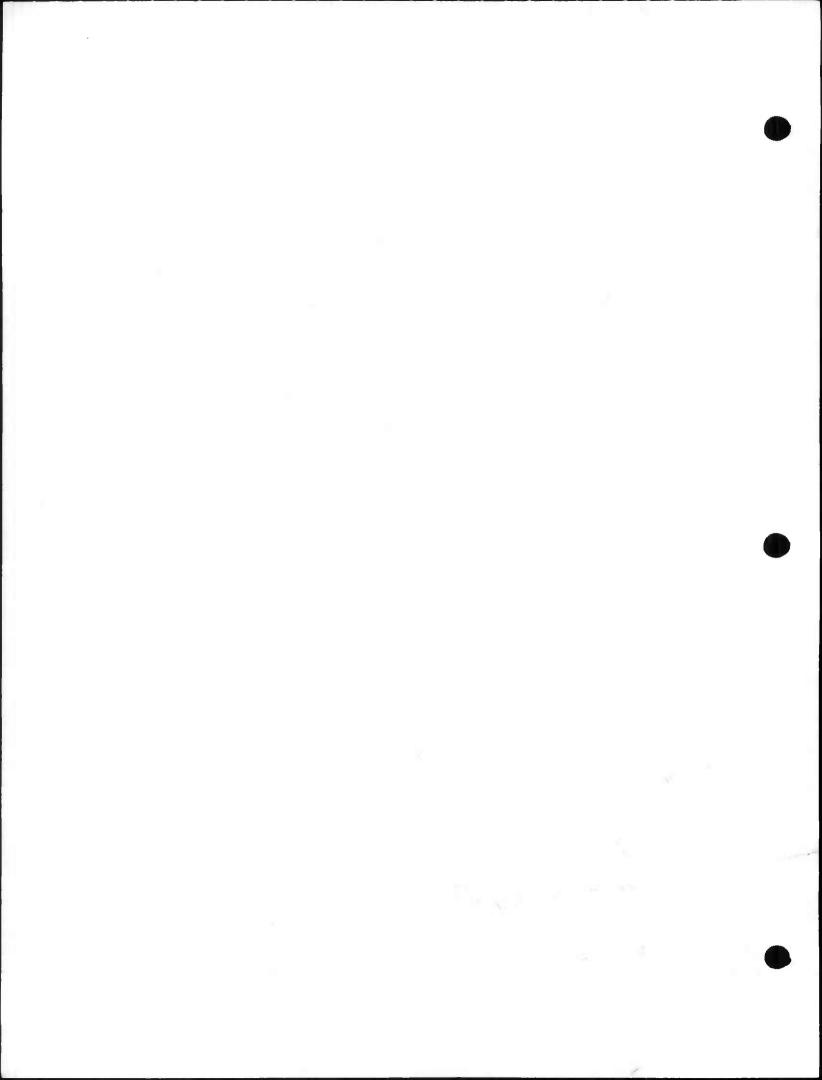
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IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Lest)					2. DATE OF DEATH		3. TIME OF DEATH			
	WANDA VE	erginia Myer		YER		MONTH 31		06:25 PM			
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (State or Foreign			
	234-32-4899	1 M 2 XF 69		MONTHS DAYS	HOURS MIN.	(Month, Day, Year) 6-25-1923		Country)			
	9a. FACILITY NAME (If not institution, give street		,					ESŤ VIRGINIA			
00			T A TO TO N		OR LOCATION OF DE	ATH	9c. COUNTY				
DIRECTOR	NORTH ARUNDEL HOS	PITAL ASSOC	LATION	GLEN	BURNIE		A	.A. COUNTY			
Diameter 1	10s. STATE 10s. COUNTY		Inc CIT	, TOWN OR LOCA	TION						
<u>=</u>	MARYLAND ANNI	E ARUNDEL	200	LEN BURN				10d. INSIDE CITY LIMITS?			
	10e. STREET AND NUMBER	ARONDED						1 TES 2 XXNO			
₹				10	f. ZIP CODE			OF WHAT COUNTRY?			
FUNERAL	113 HAMMARLEE ROAD				21060		U.S.A				
5		2. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED			IC ORIGIN? (Specify Yes	or No 14.	RACE - American Indian, Black, White, etc.			
ВУ	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DA	ATES		ecify Cuban, Maxican 2 NO Specify:			Specify:			
					(			WHITE			
TED	15. OECEDENT'S EDUCAT (Specify only highest grade co		16a. DECEDENT'S (Give kind of v	ork done during me		16b. KIND OF BU	SINESS/INDUST	TRY			
E	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use retired.)								
MP	9	NONE	UNIT St	PERVISE	R	SOCIAL	SECURI	TY			
COMPLET	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAM	ME (First, Middle, Maiden	Surname)				
BE (	RAYMOND L. C	COLLINS			LUCY	QU	EEN				
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a	and Number or Rural R	loute Number, City or Tow	n, State, Zip Coo	de)			
ř	JAMES O. MYER, S	SR.	113 HZ	MMARLEE	ROAD, GI	LEN BURNIE	, MARY	LAND 21060			
ΙÏ	20a. METHOD OF DISPOSITION		PLACEANDDATEC		ame of		CATION City	or Town, State			
	1 M Burlet 2 Creation State CEDAR HILL CEMETERY  1 M Burlet 2 Creation State Country or other place) CEDAR HILL CEMETERY  1 M Burlet 2 Cemetron State Cemetron State Cemetron State Cemetron Cemetron State Cemetron Sta										
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE										
	SINGLETON FUNERAL HOME 1 SECOND AVE., S.W., GLEN BURNIE, MD. 21061										
	42 PARY I STORY discourse										
	23. PART I. Emer the diseases, or con shock, or heart fellure. Lis	it only one cause on a	i tha death. Do n ech line,	ot entar the mo	da of dying, such	ss cardiac or respi	ratory arrest.	Approximata interval Between			
1 9	MANAGEMENT CALLED CO.										
	Onset and Death  Onset and Death  Onset and Death  OUE TO (OR AS A CONSCOUENCE OF):  CORONARY ARTERY SISEASE										
		OUE TO (OR AS A	CONSEQUENCE OF	):	A > - 0 .	1 6					
Z	Securedally that are distant	COR	ONAIS	Y A	RTERY	SISCH	50				
CERTIFICATION	Sequentially list conditions, if any, leading to immediate		CONSEQUENCE OF	):							
₫	cause. Enter UNDERLYING CAUSE (Disease or injury										
ᄩ	that initiated evants	DUE TO (OR AS A	CONSEQUENCE OF	):							
	resulting in death) LAST										
	PART II. Other significent conditions of	antelluding to death b									
DICAL	PREVIOUS BY	2 PACT C	44 (EA)	n the underlyin	g cause given in F	Part I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
ă	11000000	001137 07	moce E			1 🗆 YES 2	XG0	COMPLETION OF CAUSE OF DEATH?			
ME						_	-	1 YES 2 NO			
8	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				ACE OF DEATH (Che	ck only one)					
SI	. There Arthur	OSPITAL:  Inpetient 2 ER/Outpe	etlent 3 BOA	OTHER: 4 - Nursing Hom	e 5 🗆 Rasidenca 8	B  Other (Specify)					
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c, INJ	URY AT	28d. OEŞCRIBE HOW I	NJURY OCCUR	ED			
ВУБ	1 Netural 5 Pending Investigation	(MONIII, Day, rear)	INJ		PRK?						
	3 Suicide 8 Could not be	28s. PLACE OF INJURY	- At home, farm, a	treet, factory, offic		281. LOCATION (Street a	and Number or F	Rural Route Number,			
COMPLETED	4 Homicide detarmined building, etc. (Specify)										
E	298. CERTIFIER	No To the best of	er i Zestnicos		y tree in the						
MP	(Check only one)  20 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.  MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.										
8			r and/or investigation	i, in my opinion, a	eath occured at the t	time, deta and placa, an	d due to the ca	use(a) and manner as stated.			
BE	29b. SIGNATURE OF CERTIFIER	17.118			294 LICENSE NUM		29d. DATE SH	GNED (Month, Day, Year)			
TO	Cullot N-	11/11 MM			D2980	7	· 4/	1/83			
	30. NAME AND ADDRESS OF PERSON WHO C	MENETING CAUSE OF DEA	ATH (ITEM 27) (Type,	Print)	MIE MD	21061					
ļ	DR.CARLOS ZIGEL			PUTIN DUK	NIE,MD.	<u> </u>					
	31. OATE FILEO (Month, Day, Year)	12. REGISTRAR'S SIGN	ATURE 70								
	APR 06 1993	Time wandson-	Mariane								



ITEMS: 23 PART I, 28a-f, PER MEO G-698 4/14/93 93 09607

	1 - STATE REGISTRAR	STATE OF MARY	LAND / DEPAR CERTIF	TIMENT OF H	DEATH AND	MENTAL HYGIEN		0 3 0 0 1
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	-	3. TIME OF DEATH
	Herbert		McGe	e		03 3		3 9 . 47 D M
	4. SOCIAL SECURITY NUMBER 212 58 7488		(In yrs. lest birthday)  O YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH	8.	BIRTHPLACE (State or Foreign Country)
	9e. FACILITY NAME (If not institution, give s		U THS.	OF CITY TOWN O	OR LOCATION OF D			
8	1005 Kevin Ro	•					9c. COUNTY	/ OF DEATH
ظ	RESIDENCE OF DECEDENT  100. STATE  100. COUNT				nore Ci	ty		
DIRECTOR	Md.	,	10c. CIT	y, town or locat Baltimo				10d. INSIDE CITY
	10e. STREET AND NUMBER				. ZIP CODE		10a CITIZE	1 YES 2 □ NO
EB/	1005 Kevin Rd.			100	21229		USA	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER FORCES? 1 ₹ YES	IN U.S. ARMED	13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Specify Yes	or No- 14	RACE — American Indian, Black, White, etc.
BY	12 Never Married 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR I			2X NO Specif	in, Puerto Rican, atc.) y:	B	fack
	15. DECEDENT'S EDU		16s. DECEDENT'S	USUAL OCCUPATIO	DN .	16b. KIND OF BU		
Ē	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of a	work done during mos se_retired.)	st of working	Carrier Calle		
COMPLETED			We	elder		Stee	Τ	
	17. FATHER'S NAME (First, Middle, Last) Herbert McGee				18. MOTHER'S NA	ME (First, Middle, Melden rude (Wil	Surname)	Linton
B	19a. INFORMANT'S NAME (Type/Print)		10h MAII ING	ADDRESS (Charles				
2	Gertrude Wilso	n	925	Bridge	view Rd	Route Number, City or Tow Balto.	, Md.	21225
5	20asMETHOD OF DISPOSITION 12CPBurlel 2 Cremetion 3 Remo	20	b. PLACE AND DATE	OF DISPOSITION (No.	me of	DATE 20c. LO	CATION — City	y or Town, State
	4 Donation 5 Other (Specify)		Arbutus	ther plece)		4/8 B	alto.	, Md.
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	4		D ADDRESS OF FA	rton & S	ons	
2		a. Mor		1701	Lauren	s St. Ba	lto.,	Md.21217
	23. PART I. Enter the diseases, or of ahock, or heart fellure.	complications that cause List only one cause on o	ed the deeth. Do reach line.	not enter the mod	de of dying, suc	h ss cerdlec or reepi	ratory srrest	t, Approximete Interval Between
	IMMEDIATE CAUSE (Final disesse or condition	1/2 +	2/1	. 4.				Onset and Death
1	resulting in death)	DUE TO (OR AS	A CONSEQUENCE OF	EQUIDALA Fi:	ND ALC	OHOL INTO	OXICA.	TION
Z	Samuel Market Market College	b						į
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS	A CONSEQUENCE OF	F):				
FIC	CAUSE (Disease or injury that initiated events	DUE TO (OR AS	A CONSEQUENCE OF	F):				
R	resulting in death) LAST	d						
	PART ii. Other significent condition	a contributing to death i	but not regulting i	in the underlying	seves slues la	Bank I as summan		
PHYSICIAN: MEDICAL			out not resulting t	in the underlying	cedae given in	PERFOR	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE
						1 XYES 2	□ NO	OF DEATH?  1 ☑ YES 2 □ NO
Z								TE TES 2 INO
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			ACE OF DEATH (Ch	eck only one)		
Ιλ	14 YES 2 NO	1 Inpatient 2 ER/Out				6 Other (Specify)		
	27. MANNER OF DEATH  1 Neturel 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	285. TIMI INJ	URY WOR	RK?	28d. DEŞCRIBE HOW II	NJURY OCCUR	ED
βÁ	2 Accident Investigation 3 Suicide 8 Could not be	3 / 3 1 / 9 3 284. PLACE OF INJURY	Y — At home, farm, s	Itreet, factory, office	ES 2) NO	261. LOCATION (Street a	and Number or [	Burel Boute Number
COMPLETED	4 Homicide determined	building, atc. (Spe	iciry)			City or Town, Stete)	in Rd	
PLE	290. CERTIFIER (Check only	CIAN: To the best of my know		ed at the time, date	and piece, end due			
O.								euse(s) end menner as stated.
l w l	296. SIGNATURE AND TITLE OF CERTIFIER	. ) . * //			29c. LICENSE NUN	ABER	29d. DATE SI	IGNED (Month, Day, Year)
TO B	wonald of C	weight N	10		O.C.N	1.E.	<b>D</b>	04/01/1993
-	30. NAME AND ADDRESS OF PERSON WHO							
	DONALD G. WRIGH 31. DATE FILED (Month, Day, Year)	32. REGISTRAN'S SIGN	VATURE	n Stre	et, Bal	timore,	Maryl	and 21201
	APR 06 1993	filia Davidson-1	andell					

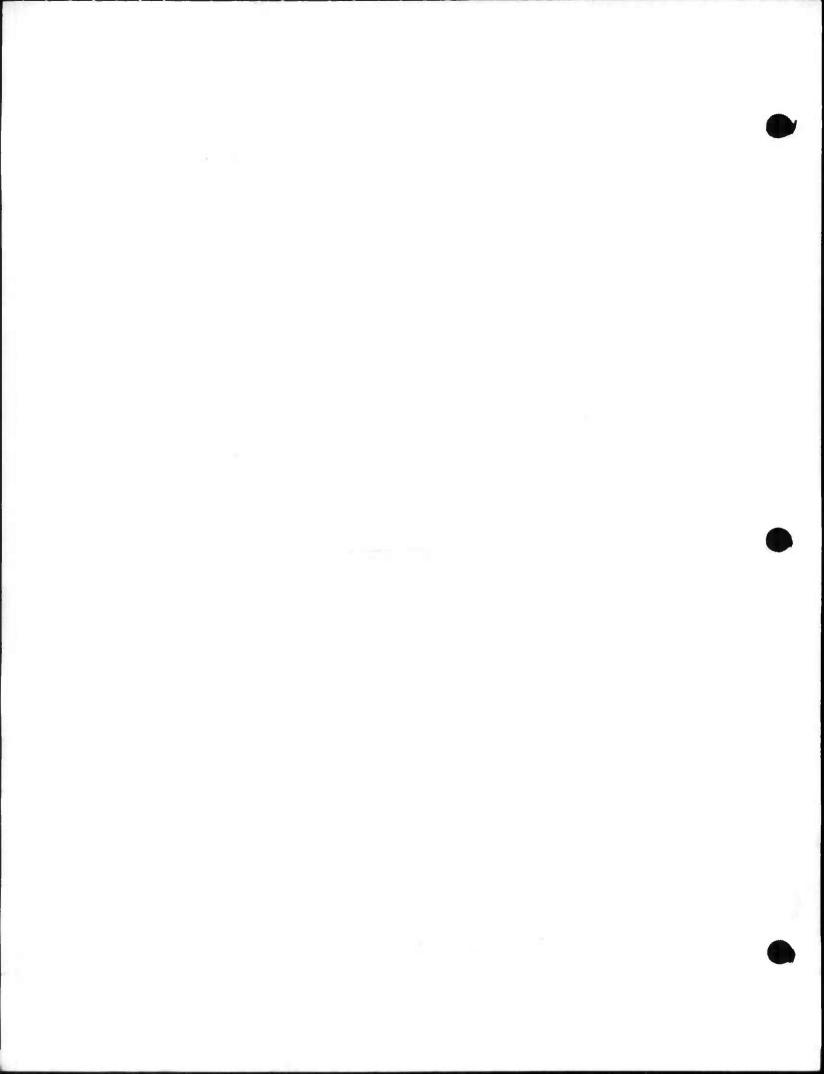
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

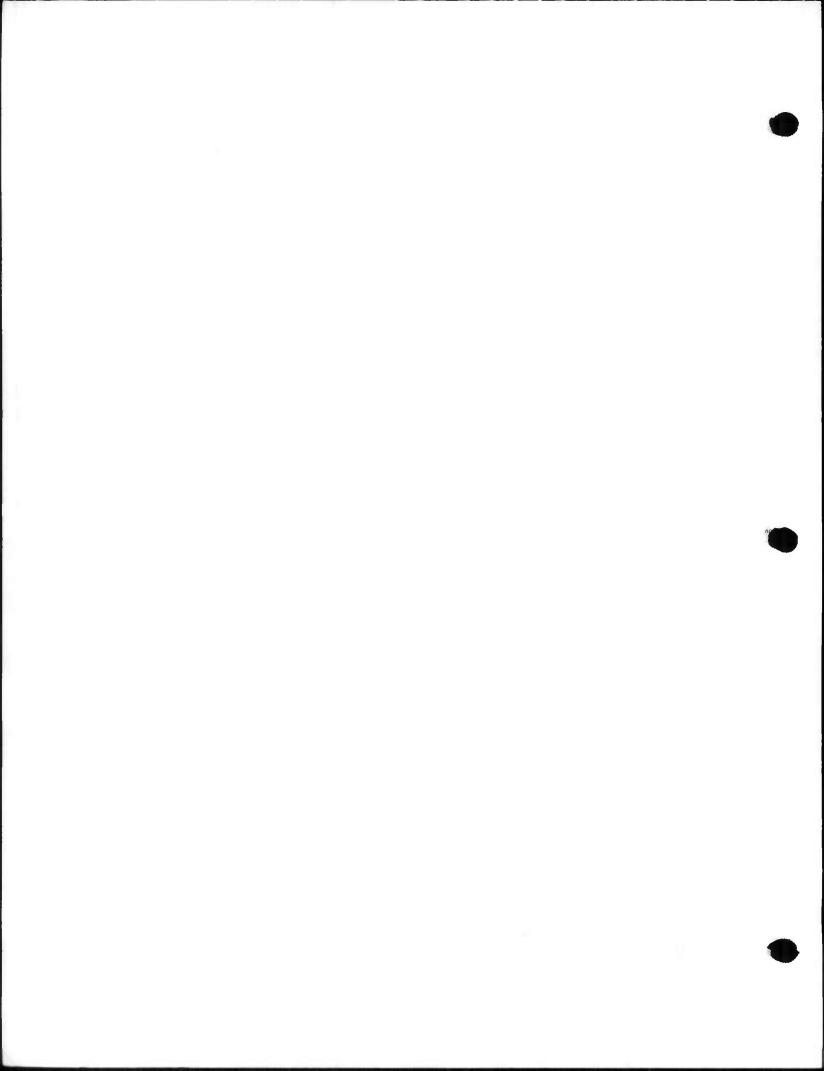
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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Linux after	TO THE CONDITION OF After this certificate has been signed by the attending physician and completely filled in by the	1

	REGISTRAR  1. DECEDENT'S NAME (First, Middle, Last)  CATUE	Cather	ine T.		Gill		DEATH		REG.		year 93 3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. lea	at birthday)	IF UNDER	1 YEAR	IF UNDER 24 I	HRS. 7.	DATE OF BIRTH		6. BIRTHPLACE (State or Foreign	
	217 40 9321	1 🗆 M 2 💢 💢	76	YRS.	MONTHS	DAYS	HOURS N	MIN.	(Month, Day, Yea		Country) MD	
	9a. FACILITY NAME (If not institution, give	street and number)			9b. CITY	, TOWN O	R LOCATION	OF DEAT			UNTY OF DEATH	
ᄄ	Greater Laure	l Belts.	Hospi	tal	I	aur	el			P.	G.	
DIRECTOR	RESIDENCE OF DECEDENT											
뿐	Maryland Anne Arundel					10c. CITY, TOWN OR LOCATION					10d. INSIDE CITY LIMITS?	
	Maryland A	Odenton 101. ZIP CODE							1 TYES ZXXNO			
Toe. STREET AND NUMBER  109. CITIZEN OF WHAT CO USA  11. MARITAL STATUS  11. MARITAL STATUS  12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 □ YES 2 X NO 11. Marital STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— 14. RACE — Am Black, White Black, White Black, White												
	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2XX	2 If yes, specify Cuban, Maxic				ean, Puarto Rican, atc.)		14. RACE — American Indian, Black, White, alc. Specify:		
ED BY	3 Widowed 4 Divorced	15. DECEDENT'S EDUCATION 16a, OE			ECEDENT'S USUAL OCCUPATION				White			
	(Specify only highest grad Elementary/Secondary (0-12)	(completed) College (1-4 or 5	(G	ive kind of work done during most of working Do NOT use retired.)								
2	12th	College (1-4 of 5		ısew	ife				Hous	ehold	l	
COMPL	17. FATHER'S NAME (First, Middle, List)						18. MOTHER	R'S NAME	(First, Middle, Ma			
	Joseph S. Sea	rs					Ann	ie V	Veber			
H	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRES:	S (Street at	nd Number or	Rural Rou	Route Number, City or Town, Stete, Zip Code)			
임	Charles J. Mc	Gill	-	1214	Bre	eitw	ert S	St.	Oden	ton,		
	20a. METHOD OF DISPOSITION		20b. PLACE	OF DISPO			netery, cremato				- City or Town, Stata	
	Nation 8 □ Other (Specify)	moval from State	- Hol		oss	Cen	neter	У	E	Brook	lyn, Md	
	21. SIGNATURE OF FUNERAL SERVICE A	CENSEE /	· //	11	22.	NAME AN	O AOORESS	OF FACIL	ITY			
	· Datud	4 a	andl.	h					eral E		P.A. 12 Ridg	
RTIFICATION	iMMEDIATE CAUSE (Finel disasse or condition reaulting in death)  Due to (or as a consequence of):  Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING  Onset and Deeth  // LWK 5											
CAUSE (Disease or Injury that Initiated events resulting In death) LAST  d.  d.  d.												
MEDICAL (		II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I.  OR GODY C BROWN 5 4 1 248. WAS AN AUTOPSY PERFORMED?  1 YES 2 NO  1 YES 2 NO  1 YES 2 NO										
AN:	BYPERTEN	51001										
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 NONO	HOSPITAL:	26. PLACE OF DEATH (Check only one)									
S 1	27. MANNER OF DEATH	28a. DATE OF	INJURY	28b. TII	WE OF	28c. INJ	URY AT		6d. DESCRIBE H		OCCURED	
¥	1 Natural 5 Pending (Month, Day, Year)				INJURY WORK?  M 1 YES 2 NO			NO ON				
ЬΗΥ	I I I I I I I I I I I I I I I I I I I							-	28f. LOCATION (Street and Number or Rural Floute Number, City or Town, State)			
ED BY PHY	1 Netural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide detarmined	28a. PLACE C	of INJURY — Al hatc. (Specify)	ome, farm,	street, fac	tory, offic		ľ			ber or Rural Route Number,	
PLETED BY PHY	2 Accident investigation 3 Suicide 6 Could not be determined  29e. CERTIFIER (Check only 1) CERTIFYING PHY	28a. PLACE (building.	atc. (Specify) my knowledge, d	eath occur	red at the	time, data	and place, ar	nd due to	City or Town, the cause(a) and	State) d manner ea a		
ETED BY PHY	2 Accident investigation 3 Suicide 6 Could not be determined  29e. CERTIFIER (Check only 1) CERTIFYING PHY	28a. PLACE ( building,  SICIAN: To the best of NER: On the bests of a	atc. (Specify)  my knowledge, d  xamination and/or	eath occur	red at the	time, data	and place, and eath occured	nd due to	City or Town, the cause(a) and place	d manner as a	stated.	

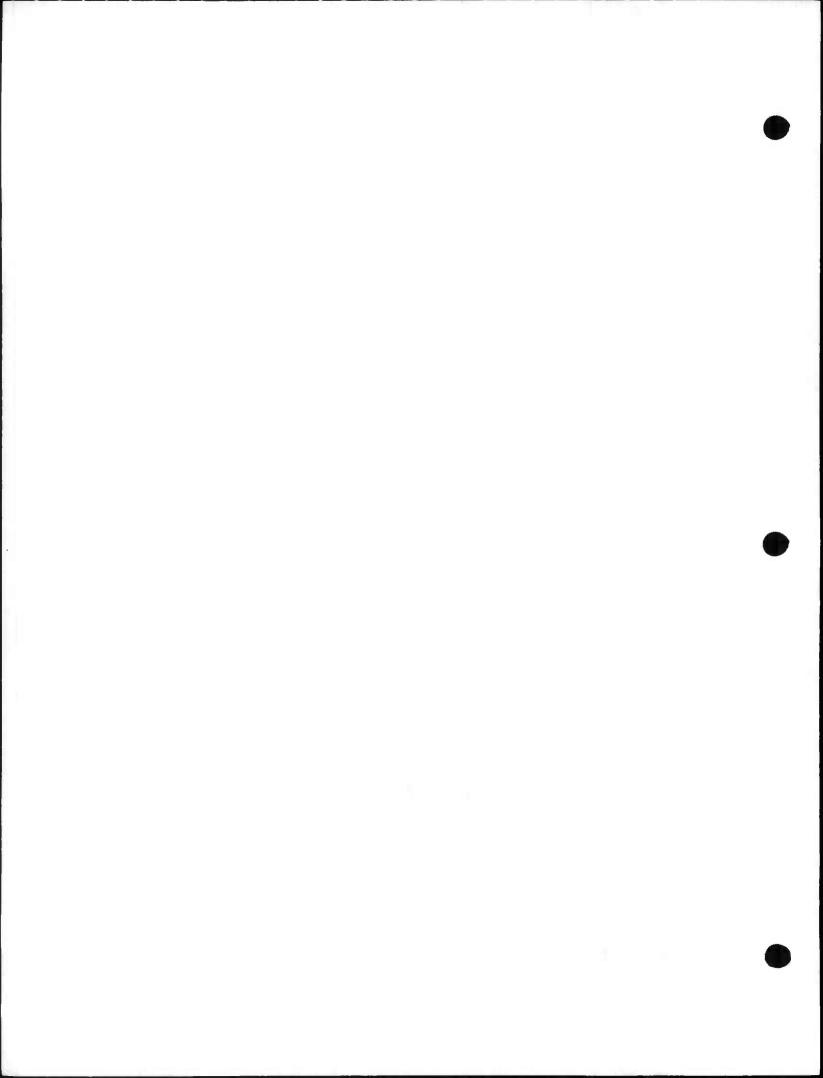


DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY FUNERAL DIRECT	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
if examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, wal.	IN THE LUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, by Elect within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
ier death. Page 6 may be retained by the hospital or attending physician.	THE LINE OF ALL ENDING PHYSICIAN; THE JAW FEQUINES THAT THE DEATH CENTICAL WITHIN 24 FOURS ARE DEATH, PAGE 6 MAY BE RETAINED by the hospital or attending physician.

BALTIMORE, MARYLAND 21215-0020

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF H	IEALTH AND M	HENTAL HYGIEN		0,000.	
į,	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEAT	ľΝ
	Richard Keith	McCarthy				April 3.	199	YEAR 3	м
1 8	4. SOCIAL SECURITY NUMBER		in yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8	BIRTHPLACE (State or Fo	preign
	217-94-9287	1	YRS.	DAYS	HOURS MIN.	(Modin. 21) par) 6	4	faryland	
DIRECTOR	99. FACILITY NAME (If not institution, give so 1497 Warfield RESIDENCE OF DECEDENT	· ·		<b>ss. crry, тоwn c</b> Edgewa	ter	ATN	77.	y of DEATH P ARundel	
EC	10s. STATE 10b. COUNT		10c. CITY,	TOWN OR LOCAT	ION			10d. INSIDE CITY	
	MD Anne	Arundel	Edge	water				1 TES 2 T	NO
FUNERAL	1497 Warfield	Road		101	21037		10g. CITIZE	N OF WHAT COUNTRY?	
BY FUN	11. MARITAL STATUS  1 Never Married 2 Married  3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	20NO	If yee, sp	ENDENT OF HISPANIC ecity Cuben, Mexicen, 2 NO Specify:		or No — 14	RACE — American India Black, White, etc. Specify: White	
8	15. DECEOENT'S EDU (Specify only highest grade	CATION	16a. DECEDENT'S U	SUAL OCCUPATION	DN	16b. KIND OF BUS		STRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille. Do NOT use			Dual &	Asso	ociates	
MP	12		Cont	ractor		Comput	er De	ept.	
	17. FATNER'S NAME (First, Middle, Last)	1				E (First, Middle, Maiden	-		
BE	John P. McCart  194. INFORMANT'S NAME (Type/Print)	iny				ey A. Ta			
2	John McCarthy					oute Number, City or Town		MD 21037	
	20e. METHOD OF DISPOSITION 1   Burlal 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	comi from State	PLACE AND DATE OF etery, cremetory or oth	er plece)				y or Town, State	
	21. SIGNATURE OF FUNERAL SERVICE LIC	ceyeyfe/j	akemont	22. NAME AN	ID ADDRESS OF FACI	ILITY		nville, M	D
	· Datt ful	UK.				eral Hom ve. Anna			1
$\neg$	23. PART I. Enter the diseeses, or	complications that caused	tha death. Do no						
	immediate cause (Fine)	a. CAV dia DUE TO (OR AS A)	ich line.					interval Be Onset and	etween
CERTIFICATION	Sequentially list conditions, if any, leading to immediate		CONSEQUENCE OF):				gnol	M	
A L	PART il. Other significant condition	a contributing to death be	at not reaulting in	the undarlying	ceuse given in P	art I. 24a. WAS AN		24b. WERE AUTOPSY FIN	
PHYSICIAN: MEDIC						1 TYES 2		COMPLETION OF COOP DEATH?	AUSE
¥	25. WAS CASE REFERRED TO MEDICAL			28. PL	ACE OF OEATN (Chec	k only one)			-
Sign	EXAMINER?	HOSPITAL: 1 Inpetient 2 ER/Output	ntlent 3 DOA 4	OTHER:	5 Rasidence 8	Other (Specify)			
	27. MANNER OF DEATN  1 Netural 5 Pending Investigation	28e. DATE OF INJURY (Month, Day, Year)	4 40 28b. TIME	OF 28c. INJI	URY AT	28d. DESCRIBE NOW IN	JURY OCCUP	RED	
red BY	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, etc. (Speci	— At home, ferm, str			281, LOCATION (Street e City or Town, State)	nd Number or	Rural Route Number,	
COMPLETED		CIAN: To the best of my knowle							nted .
	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMB				-
B	miceles	2 Pinto	(C)		D-21		DATE S	GNED (Monthy Day, Year)	- 1
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETEO CAUSE OF DEA	TN (ITEM 27) (Type, P	rint)				13/73	$\dashv$
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA		-					
	APR 06 1993 gu	ha Davidson-Rand	ARC			<u> </u>			
								UHMH-15	Rev 1/89



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VITAL	IAN: The law	Ifficate has t	Dept.	r Hem 23 s
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attending physician.	use as the burial-transit permit. Pages 1, 2, 3 should	
TENTING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	ENTRY And the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be made the state Dept. of Health and Memal Hygiene prior to burial, cremation, or removal.	I is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
STTENDING PHYSI	SEEDRIANS DIS CO	s-26 is marked,

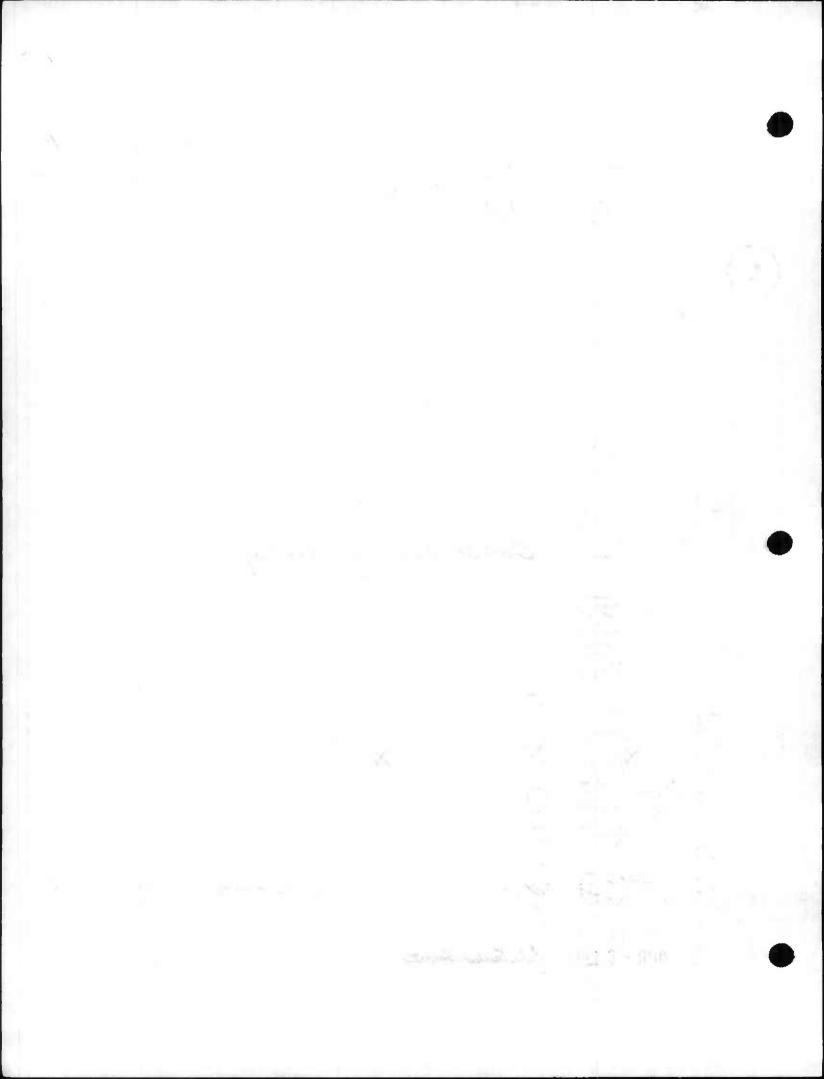
										)	0	0 1 0 1 0
	FOR 1 - STATE REGISTRAR	STATE OF MA			TMENT (							
	1. DECEDENT'S NAME (First, Middle, Last)		- 01	chiii	ICAIE	Ur L	JEAIN		REG. NO.			3. TIME OF OEATH
à	George S.	Michaels							O 3	"29	YEAR	ID: 40PM
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. les	st birthday)	IF UNDER t		IF UNDER 24 H	AS. 7. D	ATE OF BIRTH	-	S. BIRTI	HPLACE (State or Foreign
	007 46 4562	1 😡 M 2 🗆 F	46	YRS.	MONTHS E	DAYS I	HOURS M	m. Ma	Worth, Day, Year) arch 61	947	Count	Maine
	Se. FACILITY NAME (If not institution, give s		9b. CITY, TI	OWN OR	LOCATION C				NTY OF D			
6 R	Suburban Hospi		Bet	hes	sda			Mor	ntgo	omery		
EC	RESIDENCE OF DECEDENT  10e. STATE 10b. COUNTY	Y		10c. CIT	Y, TOWN OR	LOCATIO	N					10d. INSIDE CITY
DIRECTOR	Maryland Mont	gomery			lver							LIMITS?
AL.	10e. STREET AND NUMBER						IP CODE			10g. CITI	ZEN OF Y	WHAT COUNTRY?
FUNERAL	11215 Oak Leaf						209	01			USA	A
E	11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEDENT EX FORCES? 1	YER IN U.S. AR	NO	13. WA	S DECEN	IDENT OF HI	SPANIC OF	RIGIN? (Specify Yea erto Rican, etc.)	or No—	14. RACI	E — American Indian, k, White, etc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR	OR DATES		1 [	YES 2	NO S	pecify	,		Spec	
	15. DECEDENT'S EDU	CATION	16a. DE	CEDENT'S	USUAL OCC	UPATION			16b. KIND OF BUS	INESS/IND	USTRY	***************************************
Ē	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Gi	ive kind of v Do NOT us	work done duri se retired.)	ing most	of working					
COMPLETED		1	Tec	hni	cal A	dvi	sor		Electr	ical	l Sc	chool
	17. FATHER'S NAME (First, Middle, Last)					1			irst, Middle, Maiden	Sumame)		
BE	Sheldon Michae	els	1			$\perp$			Koss			
2	Susan Baker		- 1						Number, City or Town			20052
	20s. METHOD OF DISPOSITION		_		OF DISPOSITION				OCKVIII	CATION -		20853
	1 💢 Burial 2 🗆 Cremation 3 🗆 Rame 4 🗆 Donation 5 🗆 Other (Specify)	oval from State	cemetery, cre	matory or or Day	ther place)	m C	arde	nsid	4/1 Fa1	15 (	hur	ch.VA
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE			22. NA	ME AND	ADDRESS O	F FACILITY	1			
<	Duna I	Medent	6.						Funera			s n,VA 22201
	23. PART I. Enter the disesses, pr	complications that ca	sused the de	sth. Do r								Approximate
	shock, or heart failure.	List only one cause	on each line	).				7.5	***************************************		9.5.1	interval Batween Onset and Death
	disease of condition resulting in death)	- MYOU	indus	0, 10	Alan C	Lin	7					>/
96	toodiming in doding	a	No.		E 1.5 W .							74/3
		DIE TO (OR	AS A CONSEC	OUENCE OF		AIV						7413
NO	Sequentially list conditions,	DØE TO (OR	AS A CONSEC	OUENCE OF	V	ΛΙ	1					7413
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DØE TO (OR	AS A CONSEC	OUENCE OF	7):	A10						74/3
IFICATION	if any, leading to immediate	с	AS A CONSEC									748
ERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	с							-			743
L CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	cDUE TO (OR	AS A CONSEC	DUENCE OF	F):	orlying o	ause diver	in Part	260 MMS AN	VPROTILIA	246	243
<u> </u>	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	cDUE TO (OR	AS A CONSEC	DUENCE OF	F):	orlying c	cause given	n in Part	PERFOR	MEO?	24b	. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE
5 1	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	cDUE TO (OR	AS A CONSEC	DUENCE OF	F):	orlying c	cause giver	n in Part		MEO?	24b	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	cDUE TO (OR	AS A CONSEC	DUENCE OF	F):	orlying c	cause giver	n in Part	PERFOR	MEO?	24b	AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significent condition	DUE TO (OR d	AS A CONSEC	DUENCE OF	r): In the unde		cause giver		PERFOR	MEO?	24b	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST  PART II. Other significent condition	cDUE TO (OR	eth but not r	resulting I	in the unde	26. PLAC	DE OF DEATH	I (Check on	PERFOR	MEO?	24b	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
5 1	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST  PART II. Other significent condition	d.  DUE TO (OR  d.  Secontributing to dec	eth but not re	cesulting	OTHER: 4   Nursing	26. PLAC g Home lc. INJUR WORK	CE OF DEATH  5 Pesider  Y AT	I (Check on nee 6 🗆 (28d.	PERFOR 1 VES 2	MEO?		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST  PART II. Other significent condition	DUE TO (OR  d.  Its contributing to dea  PLANTIC  HOSPITAL:  1 The partient 2 ER  28e. DATE OF INJI  (Month, Dey, Y	eth but not r	resulting	OTHER: 4 □ Nursing E OF URY M	26. PLAC g Home c. INJUR WORK 1  YES	CE OF DEATH  5  Residen	I (Check on nee 6 ( 28d.	PERFORM 1 VES 2  Ny one) Other (Specify) DESCRIBE HOW IN	MEO?  NO	CURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1/22 YES 2 NO
BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST  PART II. Other significent condition	DUE TO (OR  d.  S contributing to dee  PLANTIC  HOSPITAL:  1-Appetient 2 = ER	eth but not re  ////// //// //// //// //// //// ///	resulting	OTHER: 4 □ Nursing E OF URY M	26. PLAC g Home c. INJUR WORK 1  YES	CE OF DEATH  5 Pesider  Y AT	1 (Check on nee 6 ( 28d. ) 28f.	PERFOR  1 VES 2  Ny one)  Other (Specify)	MEO?  NO	CURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1/22 YES 2 NO
BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST  PART II. Other significent condition	DUE TO (OR  d.  BE contributing to dee  HOSPITAL:  1 hopstient 2 ER  28e. DATE OF INJ  (Month, Dey, Ye  28e. PLACE OF IN  building, etc.	eth but not reconstruction of the control of the co	DOA DOA 28b. TIM INJ	OTHER: 4 Nursing E OF 28 URY M	26. PLAC g Home Bc. INJUR WORK 1  YES	CE OF DEATH  5  Resider  Y AT  7 2 NO	1 (Check on nee 6 ( ) 28d.	PERFOR  1 VES 2  Ny one)  Other (Specify)  DESCRIBE HOW IN  LOCATION (Street a City or Town, State)	MEO?  NO  NO  NJURY OCC	CURED or Rural F	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1/22 YES 2 NO
BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST  PART II. Other significent condition	DUE TO (OR  d.  BE contributing to deel  PLANTICE  HOSPITAL: 1 hospital: 28e. DATE OF INJ (Month, Dey, Ye  28e. PLACE OF IN building, etc.	eth but not reconstruction of the control of the co	DOA DOA 28b. TIMM	OTHER: 4 Nursing E OF 28 URY M	26. PLAC g Home lc. INJUR WORK 1 YES , office	5 Resider 7 AT 7 2 NO	l (Check on nee 6 28d.)	PERFOR  1 VES 2  Ny one)  Other (Specify)  DESCRIBE HOW IN  LOCATION (Street a City or Town, State)	MEO?  NO  NJURY OCC  Ind Number	or Rural F	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1/2 YES 2 NO  Route Number,
COMPLETED BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST  PART II. Other significent condition	DUE TO (OR  d.  BE contributing to deel  PLANTICE  HOSPITAL: 1 hospital: 28e. DATE OF INJ (Month, Dey, Ye  28e. PLACE OF IN building, etc.	eth but not reconstruction of the control of the co	DOA DOA 28b. TIMM	OTHER: 4 Nursing E OF 28 URY M	26. PLAC g Home lc. INJUR WORK 1  YEs , office , data an	DE OF DEATH  5  Resider  Y AT  7  2  NO	28d.	PERFOR  1 VES 2  Ny one)  Other (Specify)  DESCRIBE HOW IN  LOCATION (Street a City or Town, State)	MEO?  NO  NUTRY OCC  Ind Number	or Rural f	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  142 YES 2 NO  Route Number,
BE COMPLETED BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST  PART II. Other significent condition	DUE TO (OR  d.  BE contributing to deel  PLANTICE  HOSPITAL: 1 hospital: 28e. DATE OF INJ (Month, Dey, Ye  28e. PLACE OF IN building, etc.	eth but not reconstruction of the control of the co	DOA DOA 28b. TIMM	OTHER: 4 Nursing E OF 28 URY M	26. PLAC g Home lc. INJUR WORK 1  YEs , office , data an	5 Resider 7 AT 7 2 NO	28d.	PERFOR  1 VES 2  Ny one)  Other (Specify)  DESCRIBE HOW IN  LOCATION (Street a City or Town, State)	MEO?  NO  NUTRY OCC  Ind Number	or Rural f	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1/2 YES 2 NO  Route Number,
E COMPLETED BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST  PART II. Other significent condition	DUE TO (OR  d.  BE contributing to deel  PLANTICE  HOSPITAL: 1 hospital: 28e. DATE OF INJ (Month, Dey, Ye  28e. PLACE OF IN building, etc.	eth but not re  Control  Courtelient 3  URY — At hor (Specify)  knowledge, de- instion and/or i	DUENCE OF Cesulting I	OTHER: 4   Nursing E OF 28 URY M street, factory	26. PLAC g Home c. INJUR WORK 1  YES , office	DE OF DEATH  5	28d.	PERFOR  1 VES 2  Ny one)  Other (Specify)  DESCRIBE HOW IN  LOCATION (Street a City or Town, State)	MEO?  NO  NUTRY OCC  Ind Number	or Rural f	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  142 YES 2 NO  Route Number,
BE COMPLETED BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST  PART II. Other significent condition	DUE TO (OR  d.  BE contributing to dee  PLANTIC  HOSPITAL:  1 Dispetient 2 ER  28e. DATE OF INJ.  (Month, Dey, V.  28e. PLACE OF IN.  building, etc.	eth but not re  Control  Courtelient 3  URY — At hor (Specify)  knowledge, de- instion and/or i	DUENCE OF Cesulting I	OTHER: 4   Nursing E OF 28 URY M street, factory	26. PLAC g Home c. INJUR WORK 1  YES , office	DE OF DEATH  5	28d.	PERFOR  1 VES 2  Ny one)  Other (Specify)  DESCRIBE HOW IN  LOCATION (Street a City or Town, State)	MEO?  NO  NUTRY OCC  Ind Number	or Rural f	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  142 YES 2 NO  Route Number,
BE COMPLETED BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE. (Disease or injury that initiated events resulting in desth) LAST  PART II. Other significent condition	DUE TO (OR  d.  BE contributing to dee  PLANTIC  HOSPITAL:  1 Dispetient 2 ER  28e. DATE OF INJ.  (Month, Dey, V.  28e. PLACE OF IN.  building, etc.	eth but not recommend to the commendation of t	DUENCE OF Cesulting I	OTHER: 4   Nursing E OF 28 URY M street, factory	26. PLAC g Home c. INJUR WORK 1  YES , office	DE OF DEATH  5	28d.	PERFOR  1 VES 2  Ny one)  Other (Specify)  DESCRIBE HOW IN  LOCATION (Street a City or Town, State)	MEO?  NO  NUTRY OCC  Ind Number	or Rural f	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  142 YES 2 NO  Route Number,

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detached	rs after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	once
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funeral		as a marked or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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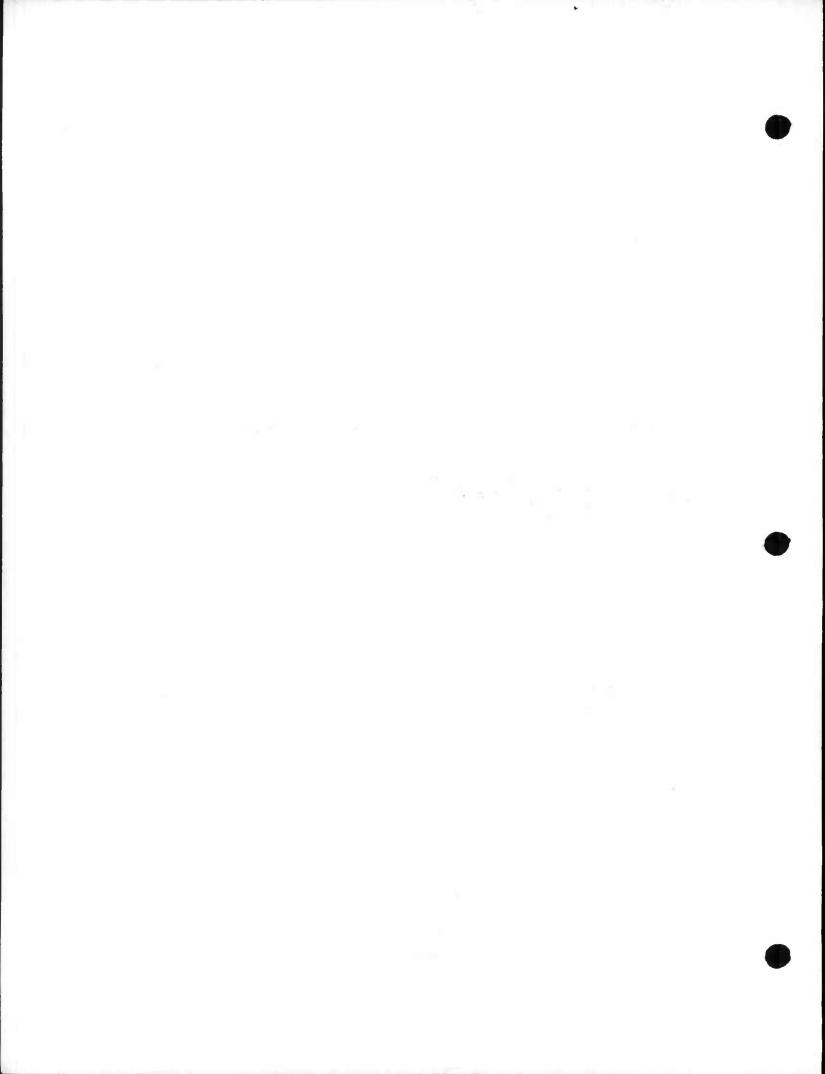
	ddle, Last)					2. DATE OF DEATH		3. TIME OF DEATH		
Claire Vi	cent Mu	lliken				April 0		13 12 45		
4. SOCIAL SECURITY NUMBER	5. SE	B. AG	E (In yrs. lest birthda			7. DATE OF BIRTH (Month, Day, Year)	6	BIRTHPLACE (State or Forei		
038-01-(2-1	3501 1□	M 2 X F	83 YRS	MONTHS DA	YS HOURS MIN.	March 02	1010	Rhode Island		
9e. FACILITY NAME (If not institu			7	9b. CITY, TO	WN OR LOCATION OF I	DEATH	9c. COUNT	Y OF DEATH		
Manor Care -			Zenka,	) T	owson		Ba1	timore		
10e. STATE 10b. COUNTY			10c.	CITY, TOWN OR LO	OCATION			10d. INSIDE CITY		
Maryland	Balti	imore		Cocke	eysville			1 TES 2 NO		
10e. STREET AND NUMBER					101. ZIP CODE		10g. CITIZE	EN OF WHAT COUNTRY?		
10 Beehive					21030		US	SA		
1. MARITAL STATUS  Never Married 2 Married  Never Married 2 Married  Never Married 4 Divorced  12. WAS DECEDENT EVER IN U.S. ARME FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES				If yes		ANIC ORIGIN? (Specify can, Puarto Rican, etc.) ://y:		4. RACE — American Indian, Black, White, etc. Specify:		
								White		
(Specify only highest grade completed)			(Give kind	T'S USUAL OCCUI of work done during T use retired.)	PATION g most of working	16b. KIND OF	BUSINESS/INDU	STRY		
Elementary/Secondary (0-12	Colle	ege (1-4 or 5+)								
	1500		Hous	sewife		IAME (First, Middle, Maid	emaking	3		
17. FATHER'S NAME (First, Middle Henri Leon	14-3-7									
19a. INFORMANT'S NAME (Type			105 14411	ING ADDRESS (C.		Louise H		Payle)		
Thomas B. Se				the same of the same of				land 21093		
20a. METHOD OF DISPOSITION			20b. PLACE AND D	ATE OF DISPOSIT	TION (Name	DATE 20c.	LOCATION CI	ty or Town, State		
X Burial 2 Cremation	3 🗆 Removal fr	om State	of cometary, crema	tory or other place	lem. Grdne	4/6/03	Timonie	m, MD 21093		
21. SIGNATURE OF FUNERAL S					E AND ADDRESS OF F		monite	IID 21093		
<b>•</b> •	0.7					ell-Wiede				
Bryan W  23. PART I. Enter the dise								n, MD 21093		
iMMEDIATE CAUSE (Final disease or condition resulting in death)		Carc DUE TO (OR A	A PON	DA OF	lus	ng.		Onset and E		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST										
readiting in death) EAST	d									
PART II. Other algorificent	conditiona con	tributing to deat	h but not regulti	ng in the under	fying cause given i	PER	AN AUTOPSY FORMED?	24b. WERE AUTOPSY FINE AMAILABLE PRIOR TO COMPLETION OF CAU OF DEATH?  1 YES 2 NO		
1.7		,				_		10,725 20,700		
25. WAS CASE REFERRED TO I					6. PLACE OF DEATH (	Check only one)				
1 TES 2 NO		SPITAL:	Outpatient 3 🗆 DO	A 42 Nursing	Home 6 - Residence	a 6 Other (Specify)				
27. MANNER OF DEATH		28a. DATE OF INJUI (Month, Day, Yes	RY 26b.	TIME OF 280	e, INJURY AT WORK?	28d. DESCRIBE HO	W INJURY OCCI	URED		
2 Accident Inv	estigation	28e. PLACE OF INJI	IOV . At home for		YES 2 NO	Des LOCATION OF	not and At	Down Courts March		
	uid not be termined	building, atc. (S		, outer, rectory,	OTHER .	City or Town, S	tate)	or Rural Route Number,		
						us to the cause(s) and		d. cause(a) and manner as sta		
29b. SIGNATURE AND TITLE O	-	,			29c, LICENSE N			SIGNED (Month, Day, Year)		
4454	2/10/	lan.			1 12	20110	1 4	4-5-63		
MIIICO		UVA			11-16			7 -77 1		

No. of Street, or other teams of the street, or other teams of the



BALTIMORE, MARYLAND 21215-0020 SCIGAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Certification by the annual requirement of the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State page of Health and Mental Houlien prior in burial cremating or removal.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,  TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE RUNDAR OLDSCORE, which the State find of Hank and Mental Hospine prior in build formation or named infector, page 5 should be detached for use as the burial-trans.	IMPORTANT: If Item 28 Is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR	OTATE OF 144		20170				3 09612	I IS
	1 - STATE REGISTRAR	STATE OF MAR	YLAND / DEPA CERTIF	RTMENT OF FICATE OF	HEALTH AND I	MENTAL HYGIE REG. N			
	1. DECEDENT'S NAME (First, Middle, Last)  ELIZAB	ETH NEV	TIIS			2. DATE OF DEATH MONTH	2 9	3. TIME OF DEATH	٥
	4. SOCIAL SECURITY NUMBER 5.	SEX 6. A	GE (In yrs. lest birthday)	7	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)	in M
	212-09-4242 1 9e. FACILITY NAME (If not institution, give street		78 YRS.	MONTHS DAYS	HOURS MIN.	1/12,		Maryland	
SH				TOW	OR LOCATION OF DI	EATH		Y OF DEATH	
DIRECTOR	415 Aigbur	cii Noud	100 01	TY. TOWN OR LOCA				Baltimore	
	Maryland Ba	<u>ltimore</u>	100. 01	Towso	n			10d. INSIDE CITY LIMITS? 1 YES X X NO	
FUNERAL	415 Aigburth Ro	ad		10	21286		10g. CITIZE	N OF WHAT COUNTRY?	
NO.	11. MARITAL STATUS 12	. WAS DECEDENT EVE FORCES? 1 1 Y	R IN U.S. ARMED	13. WAS DE	CENDENT OF HISPAN	NIC ORIGIN? (Specify	fes or No— 14	USA I. RACE — American Indian,	_
BY F	1 Never Married 2 Married  3 Widowed 4 Divorced	IF YES, GIVE WAR OF	R DATES T	1 TYE	B 2/17 NO Specify	in, Puerto Ricen, etc.) y:		Black, White, atc.  Specify:	
	15. DECEDENT'S EDUCATI (Specify only highest grade corr	ON noleted)		S USUAL OCCUPATI work done during m		16b. KIND OF E	USINESS/INDUS	White	_
COMPLETED		college (1-4 or 5+)	Ille. Do NOT a	retary	ost of working	Brok	erage 1	Firm	
	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Meid	en Sumame)		
BE	Joseph L. LeBrun  198. INFORMANT'S NAME (Type/Print)	<del></del>	19b. MAII IN	G ADDRESS /Street		nie Wille		and a state of the	
5	Richard N.W.Ruach		7.5			o.Md. 212		ode)	
	20e. METHOD OF DISPOSITION  X ◯ Burlel 2 □ Cremation 3 □ Removal	from State	20h PLACE AND DATE	OF DISPOSITION /A	ame of	DATE 200	OCATION CIN	y or Town, Stata	
	4 Dodetton 5 Other (Specify)	SEE /	Dulaney	22. NAME A	ND ADDRESS OF FA	CILITY		le, Maryland	$\dashv$
	Dennis Skephen	Xenakîs	M00640		N	1itchell-W		ld Home yland 21212	
	23. PART i. Enter the diseases, or com shock, or heart failure. List	plications that cause or	sed tha death. Do n each ilne.	not antar tha m	ode of dying, auc	h as cardiac or res	piratory arres	t, Approximata	
	IMMEDIATE CAUSE (Final disease or condition resulting in death)		PHYSEI					Onset and De	
-		DUE TO (OR A	S A CONSEQUENCE O	OF):					
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR A	S A CONSEQUENCE O	OF):					$\dashv$
SE	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR A	S A CONSEQUENCE O	OFI:				!	_
FRT	resulting in desth) LAST	<u> </u>		,.					
-	PART il. Other algnificent conditions ci	ontributing to deat	but not resulting	In the underlyin	g cause given in	Part I. 24s, WAS /	IN AUTOPSY	24b. WERE AUTOPSY FINDIN	NGS
PHYSICIAN: MEDICAL	- POLYMYAZGI - GASMO ENTO	x (	SHEOMA	TICA		PERF	ORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSI OF DEATH?	- 1
ME	- GRIMO ENT	STINAL	BLEE	DING				1 TES 2/5 NO	
IAN	25. WAS CASE REFERRED TO MEDICAL			26. P	LACE OF DEATH (Ch	ack only one)		<u> </u>	_
SIC		OSPITAL:	utpatient 3 🗆 DOA	OTHER:	ne 5/ Besidence				$\dashv$
	27. MANNER OF DEATH  1 Natural 5 Pending	28a. DATE OF INJUF (Month, Day, Yea		JURY W	JURY AT DRK?	28d. DESCRIBE HOV	INJURY OCCUP	RED	$\exists$
BY	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJU	RY — At home, farm,		YES 2 NO	281. LOCATION (Street	t and Number or	Rural Bouta Number	
COMPLETED	4 Homicide determined	building, etc. (S	pecify)			City or Town, Star	6)	The state of the s	
APL	29a. CERTIFIER (Check only one)								$\neg$
00	2 MEDICAL EXAMINER: 0	n the basis of examins	tion and/or investigati	on, in my opinion, o	leath occured at the	time, data and place,			1.
TO BE	296. SIGNATURE AND TITLE OF CENTIFIER		cm =		29c. LICENSE NUN	795	29d. DATE S	4/5/93	
F	30. NAME AND APPRESS OF PERSON WHO CO	OMPLETED CAUSE OF	DEATH (ITEM 27) (Type	p, Print)	14 .		-	11 1	⊣
	John G. Lavi	n 6212 Y	ork koad	Ralt.imov	e. Marvi	and フィフィン			- 1
	31. DATE FILED (Month, Day, Year)	17 6212 Y 32. REGISTRAR'S SI Fuha Davidso	ork Road	Baltimor	re, Maryl	and 21212			$\dashv$

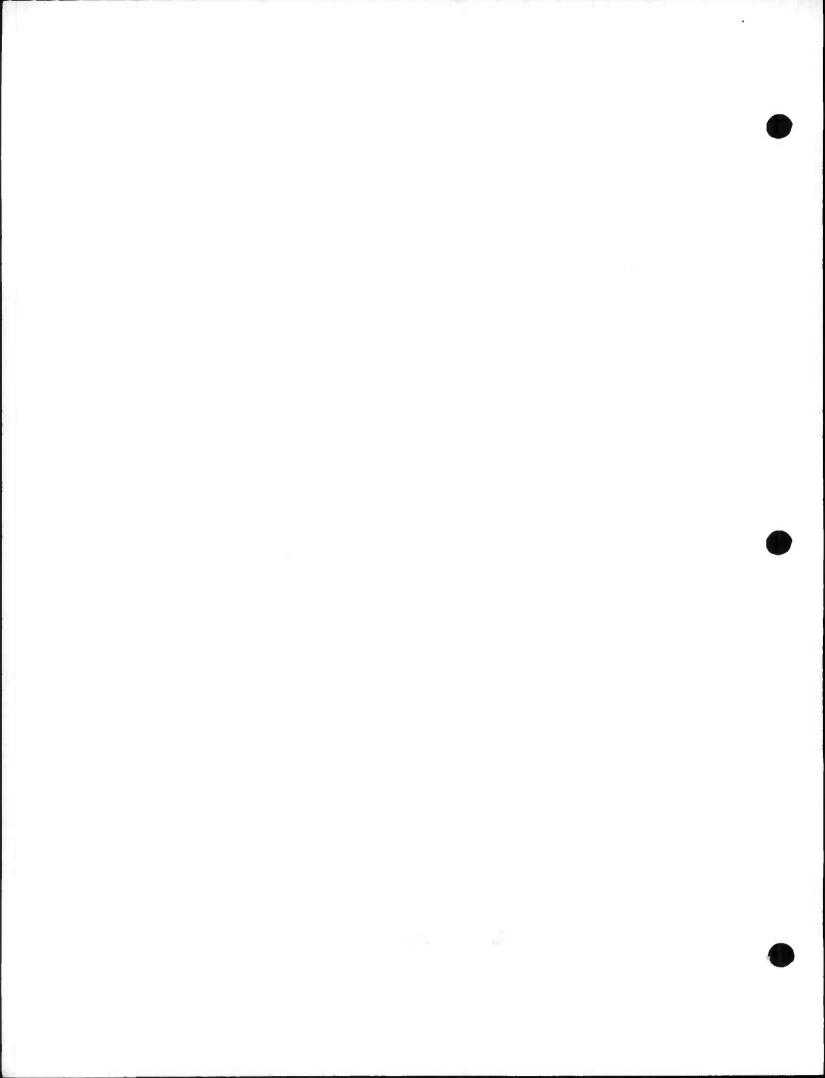


TO THE HIGGINAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be encured within 24 hours where death. Page 6 may be intained by the highest the law requires that the antifician has been signed by the attending physician and compitally filled in by the funeral direction page 5 about be detached for use as the burist-transit permit. Pages 1, 2, 3 should be sits within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burist, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumable event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REGISTRAN			EKIII	ICAL	E OF	DEATH		REG. NO.				
1. DECEDENT'S NAME (First, Mixths, Las		-11-					2. DATE OF	F DEATH DAY	YEA	3. TIME OF DEATH		
Lelia 4 SOCIAL SECURITY NUMBER		elle			SOF		0.4	0.3	199	3 1016		
		6. AGE (In yes. I		IF UNDER	DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF	PORTH Day, Wall)	8. 88 Co	RTHPLACE (State or Foreign		
579-30-5066		10 m 2 tX y					/-18-1			916 Va		
9a. FACILITY NAME (If not institution, give street and number)					98. CITY, TOWN OR LOCATION OF DEATH 96. COUNTY OF DEATH							
2812 Oakley Avenue					Baltimore							
10s. STATE 10s. COUR	16e. Cr	TY, TOWN	OR LOCAL	NON				Contract to the Contract of th				
Md	L. Control of the						10d. INSIDE CITY LIMITS?					
10s. STREET AND NUMBER					Baltimore Too. ZIP CODE				1 🔀 YES 2 🗌 NO			
2812 Oakley A	Ivanua							- 1		OF WHAT COUNTWY?		
11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S.	LUMEN	Ta		21215 ENDENT OF HISPY			USA			
1 Never Married 2 Married 3 Widowed 4 Divorced	Хмо	100	If yes, sp	ecify Cuben, Mexic 2XXNO Spec	en, Puerto Ric	(Specify Yes o an, etc.)	201120	ACE American Indian, lack, White, etc. pec#81ack				
18. DECEDENT'S ED	DUCATION	16a, C	DECEDENT'S	USUAL O	CCUPATIO	OH .	16b. K	IND OF BUSIN	NESS/INDUSTR	v		
(Specify only highest gra Elementary/Secondary (0-12)	Otr completed) College (1-4 or 5 +)		(Give kind of the Do NOT u	work done ne retired.)	during mo	at of working						
12th	202	8										
TT, FATHER'S NAME (First, Alickin, Last)		_				18. MOTHER'S N	AME (First, Mic	KNs, Mariden Si	umamej			
							700					
19a. INFORMANT'S NAME (Type/Fint)		-	ISB. MAILING	ADDRES	S (Street a	nd Number or Rure	Route Number	City or Teers.	State, Zip Code			
Mary Burton						y Avenue						
204. METHOD OF DISPOSITION	areas unional		EANDDATE	OF DISPOS	SITION (No	THE RESERVE AND ADDRESS OF THE PERSON NAMED IN	DATE	Name and Address of the Owner, where the Owner, which is the Owner,	KTION - City o			
t X Burtal 2 ☐ Cremation 3 ☐ Ra 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	cemetery, c	ng Mer	nond a	1	Park	4793	12.00		own. Md		
21. SIGNATURE OF FUNERAL SERVICE I	LICENSEE	1 5.11	19 1101	-	-	D ADDRESS OF F		I Kan	ualist	OWII. MG		
· 4 orter	a Eli	ron				ch F/H W Wabash		ie				
Sequentially list conditions, if any, leading to immediate	h.	OR AS A CONS	EQUENCE O	FI:		RPIOVA			, , , , ,			
CAUSE (Disease or Injury that initiated events resulting in death) LAST	Enter UNDERLYING  E (Disease or Injury out to (on as a consequence of):											
PART II. Other algnificant condition	resulting	in the un	iderlying	cause given in	6	YES 2	E07	NAME AUTOPSY FINDS AMALABLE PRIOR TO COMPLETION OF CALS OF DEATH? 1 VES 2 NO				
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (Check only one)										
1 XYES 2 NO	HOSPITAL:	ER/Outpetient	a ∐ boa	4   Nun	R: sing Hom	5 XResidence	6 🗆 Other (S	(pecify)				
77. MANNER OF DEATH	28e, DATE OF II	NJURY	26h. TIM		28c, INJ				URY OCCURED			
1 Natural 5 Pending 2 Accident Investigation	15500000	112000				ES 2 NO			Secretary Control of C			
3 Suicide & Could not be 4 Homicide defermined	28e. PLACE OF	INJURY — At h to (Specify)	ome, farm,	street, fact	ory, office	0.	281. LOCATI City or	ON (Street and Isen, State)	t Number or Pur	el Route Number		
98. CERTIFIER (Check only 1 CERTIFYING PHY: OVE) 2X MEDICAL EXAMIN	SICIAN: To the best of e	ny knowledge, d	leath occum	ed at the ti	ime, date pinton, de	and place, and du	to the cause time, date an	(s) and menne d place, and	or as stated. due to the caus	e(s) end menner as state		
THE SIGNATURE AND TITLA OF DESCRIPT	1) (	-	1		T	294, LICENSE NU	MILER.	- 13	194. DATE SIGN	ED (Month, Day, Mar)		
mut y	Jall -	A	4/			O.C.	MF		b	04 1993		
III. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE	DEATH (IT	EM 27) (Type	Print)	_	V. C.	Ma Lie		04	04 1993		
MAKIO T-GOLL	TAX DUM	2.11	1 Pe	nn :	Stre	eet. Ba	altimo	ore.	Maryl	and 2120		
APR 06 1993	grand bours	marken										



3. TIME OF DEATH

LACE (State or Foreign

10d. INSIDE CITY

14. RACE American Indian.

Black White etc.

1 VES 2 NO

Black

22

Approximate

24b. WERE AUTOPSY FINDINGS AWAII ABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?

1 YES 2 NO

29d. DATE SIGNED (Month, Day, Year)

intarvai Between

Onset and Death

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9c. COUNTY OF DEATH

10g. CITIZEN OF WHAT COUNTRY?

Specify

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Home

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REG. NO

2. DATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	DODITAL OD ATTENDIAL DUNCHART The last considers that death and Speed he consider his personal and the history
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Y IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH Day, Year) 8-350 HOURS YRS. page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 96. STY TOWN OR LOCATION OF DEATH, ecours DIRECTOR RESIDENCE OF DECEDENT 10b. COUNTY 10c. CUTY, TOWN OR LOCATION 2 BY FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 11070 24 hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARE FORCES? 1 YES 2 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto R

1 YES 2 NO Specify: 1 Never Merried 2 Married IF YES, GIVE WAR OR DATES 3 Widowed 4 Delivorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF SUSINESS/INDUSTRY /Secondary (0-12) College (1-4 or 5+) 2Th DOC notified at once. 17. FATHER'S NAME (First, Middle, Las 18. MOTHER'S NAME (First, Middle, Maiden Surname) harles BE 19b. MAILING ADDRESS (Street and N 9 manda 2121 W. be 20e. METHOD OF DISPOSITION
1 La Burlel 2 Cremetion 3 Ref
4 Denetion 8 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or must cemetery, cremetory or other place Arbutus DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Batto Mem examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
March Fullera 4300 medical 23. PART i. Enter tha diseasea, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, ahock, or heart fallure. List only one cause on each line. IMMEDIATE CAUSE (Finei event, the disease or condition CANCER OPHAGEAL reaulting in death) traumatic PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST 0 shows any injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 23 25. WAS CASE REFERRED TO MEDICAL item ; 26. PLACE OF OEATH (Check only one) HOSPITAL:
1 X Inpetient 2 - ER/Outpatient 3 - DOA OTHER 1 YES 2 NO 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATH 28e. OATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. OEŞCRIBE HOW INJURY OCCURED marked, INJURY 1 Natural 1 YES 2 NO ВУ 2 Accident OR ATTENDING 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 28 is a 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be determined 4 Homicide MPORTANT: If item 1 🐹 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner ee stated. THE FUNERAL D 2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(e) end menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE D290 M who 223 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 821 N. EUTAW #305

AND TARES MANUELL

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

Market S. D. Jan Bright

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DIVISION OF VITAL BECORDS, P.O. BOX 68760	IOSPITAL OR ATTENDING PHYSICIAN:
VISION	ATTENDING
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_	OSPITAL

	1 - STATE REGISTRAR	STATE OF M	ARYLAND / DE CER	PARTM TIFIC	ENT OF H	EALTH A	ND N	NENTAL HYGIEN	E	J ()	09013	
	1. DECEDENT'S NAME (First, Middle, Last) RUXTON Ca	rroll		NOV	ICKI			2. DATE OF DEATH DA O 1	γ	YEAR 3	2:55 P M	
	4. SOCIAL SECURITY NUMBER 215–43–5777	5. SEX 1 🔀 M 2 🗌 F	8. AGE (In yrs. last birth	res. MON	UNDER 1 YEAR	IF UNDER 24	HRS. MIN.	7. DATE OF BIRTH (MOTE) 1939		6. BIRTHP	LACE (State or Foreign	
POR	9e. FACILITY NAME (If not institution, give s PENINSULA REG		INTER		CITY, TOWN O		OF DE	ATH	ec. COUNT	I COM		
DIRECTOR	RESIDENCE OF DECEDENT  108. STATE  10b. COUNT  WOYCE		10-		TY, TOWN OR LOCATION					10d. INSIDE CITY LIMITS?X		
	100. STREET AND NUMBER 11513 s. Dolly C	ircle		Ber1	101	21811			U.S	EN OF WH	AT COUNTRY?	
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1.		If yes, sp	ecify Cuban,	HISPANI Mexican Specify:	C ORIGIN? (Specify Yea , Puerto Rican, atc.)	or No — 1	Black,	- American Indian, White, etc. Vhite		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondery (0-12)	EDUCATION prade completed)  College (1-4 or 5+)  4 years  16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Police Department						166. KIND OF BUS		STRY		
BE CON	17. FATHER'S NAME (First, Middle, Last)  John P. Novicki  19a. INFORMANT'S NAME (Type/Print)					A1	ice	M. Caroll				
2	Debbie Novicki  200. METHOD OF DISPOSITION		111	513 g	. Dol:	Ly Cir	cle	Berlin M	2181	11		
	1 Burial 2 Cremetton 3 Ram 4 Donation 8 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC		20b. PLACE AND C	POMEN	SPOSITION (NA Place) Gard	ens		4/6/93 Bal	timor	e MD	n, Stata	
	· martin	J. Dipp	el Je		7110 I	Belair	Ro	Dippel ad Baltimo	re MI	212	lome 206	
	23. PART i. Enter the diseases, or shock, or heart failure.  IMMEDIATE CAUSE (Final disease or condition resulting in desth)	List only one cause	e on each lina.					as cardiac or reapir			Approximata interval Between Onset and Daeth	
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	C	OR AS A CONSEQUEN									
	PART ii. Other significant condition		eath but not resul	ting in th	e Underlying	cause giv	an in F	Part i. 24a. WAS AN			PERE AUTOPSY FINDINGS	
PHYSICIAN: MEDICAL	Tobacco	Ose						PERFORI		0	MAILABLE PRIOR TO OMPLETION OF CAUSE IF DEATH?  YES 2 \( \subseteq \text{NO} \)	
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 TYPES 2 ND	HOSPITAL:	ER/Outpatient 3 🗆 D		HER:	ACE OF DEA		ck only one)				
B	27. MANNER OF DEATH  1 Netural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28s. QATE OF IN (Month, Day, 4 / 1 / 9) 26s. PLACE OF	3 2 INJURY — At home, fr	: OOF	1 1	RK? 'ES 2	10	28d. DESCRIBE HOW IN  Driver 1 28f. LOCATION (Street a)	an c	off		
COMPLETED	4 Homicide detarmined  29a. CERTIFIER (Check only 1 CERTIFYING PHYSI	building, et	ROA	DWAY		and place, a	nd due t	69 SEAI			•	
COM	one) 2 (MEDICAL EXAMINE	R: On the beels of exa									nd menner as stated.	
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIES	I Christo	MD			O . C			29d. DATE:  ▶ 4 /		fonth, Dey, Year) 3	
	30. NAME AND ADDRESS OF PERSON WELL 31. DATE-FILED. (Month, Day, Year)		111 P			et, E	Balt	imore, N	Maryl	Land	21201	
	APR 06 1993	Julia Davids	-					-:				

BALTIMORE, MARYLAND 21203-3146

	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATH		YEAR 3.	TIME OF DEATH	
	MARTHA W.					MONTH DAY YEAR 4 3 1993			М			
	4. SOCIAL SECURITY NUMBER	6. AGE (In yrs. less	birthday)	IF UNDER 1 YEA		DER 24 HRS.	7. DATE OF BIRTN (Month, Day, Year)	1,000	6. BIRTNPL Country)	ACE (State or Foreign		
	212 05 8755   1 M 2 K F   88 YRS.   M   9 4 1904									yland		
	9e. FACILITY NAME (If not Institution, give	street and number)		96. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEAT						тн		
CTOR	Maryland Manor	Nursir	ng Home		Ma	rley			Anr	ne Ar	undel	
DIREC	100. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Baltimore										Od. INSIDE CITY LIMITS?  YES 2 NO	
AL.	10e. STREET AND NUMBER			10f. ZIP C	ODE		10g. CITI	IZEN OF WHA	AT COUNTRY?			
监	115 Doris Avenue					2	21225	i	J	J.S.A		
BY FUNERAL	11. MARITAL STATUS  1 Never Merried 2 Merried  3 Widowed 4 Divorced	MED IO	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No If yes, specify Cuben, Mexican, Puerto Rican, etc.)  1. VES. 2. NO. Specify:					American Indian, White, atc.				
8	15. DECEDENT'S EDI				USUAL OCCUP		addina	16b. KIND OF BU	ISINESS/INC	DUSTRY		
1 12 1	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  Home make						irking	A.1				
COMPL	17. FATNER'S NAME (First, Middle, Last)				16. MOTNER'S NAME (First, Middle, A							
ε w	George	Wroter	1			Ca	ther	ine				
B	19e. INFORMANT'S NAME (Type/Print)		198	. MAILING	ADDRESS (Stre	et end Num	ber or Rural I	Route Number, City or Tox	vn, State, Zip	Code)		
TO BI	Edward O'Conno	or (son)		208	3 W. A	rde	n Rd.	Baltimo	ore,	MD.	21225	
1001	20e. METNOD OF DISPOSITION 1 20 Buriel 2 Cremation 3 Removal from State 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) 20c. LOCATION — City or Town, State											
	41 Donellon 6 Other (Specify) Gedar Hill Cemetery Brooklyn Park, MD.											
availiller	22. Name and address of Facility  Gonce FH 4001 Ritchie Hwy Balto 2122											
AIR INJURY, OF DUTIER LEADING COVERY, THE INSULAND	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  COROMARY ARTERY DISEASE  OUE TO (OR AS A CONSEQUENCE OF):  COROMARY ARTERY DISEASE  OUE TO (OR AS A CONSEQUENCE OF):  COROMARY ARTERY DISEASE  DUE TO (OR AS A CONSEQUENCE OF):  COROMARY ARTERY DISEASE  DUE TO (OR AS A CONSEQUENCE OF):  COROMARY ARTERY DISEASE  DUE TO (OR AS A CONSEQUENCE OF):  COROMARY ARTERY DISEASE  DUE TO (OR AS A CONSEQUENCE OF):  COROMARY ARTERY DISEASE  DUE TO (OR AS A CONSEQUENCE OF):  COROMARY ARTERY DISEASE  DUE TO (OR AS A CONSEQUENCE OF):  COROMARY ARTERY DISEASE  DUE TO (OR AS A CONSEQUENCE OF):  COROMARY ARTERY DISEASE  DI											
ME	SENILE DEMENTIA								MAILABLE PRIDR TO COMPLETION OF CAUSE OF DEATH?			
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 NO	HOSPITAL:	☐ ER/Outpatient 3	□ 000	QTHER:							
PHYS	27. MANNER OF DEATN	26a. DATE O		28b. TIN	-/	Nome 5 L		S ☐ Other (Specify)  28d, OESCRIBE NOW	INJURY OC	CURED	-	
	1 Natural 6 Pending	(Month,	Day, Year)		JURY	WORK? YES						
ETED BY	2   Accident   Investigation   3   Sulcide   6   Could not be determined	28e. PLACE	OF INJURY — At he, etc. (Specify)	me, farm,	street, factory,	office		28f. LOCATION (Street City or Town, State		or or Rural Rou	ite Number,	
MPL	(original original or							to the cause(s) and mo			end manner ee stated.	
TO BE CO	296. SIGNATURE AND TITLE OF CERTIFI	relinot	HILEND	ING	PHYS	10 (A)	LICENSE NUI	D14160	29d. DAT	SIGNEO (A	Andrin, Day, Your)	
-	30 NAME AND ADDRESS OF PERSON W	CGH M	SE OF OEATH (ITE	S ((	B'n A	RI	LCA	IE HIG	HWA	14, 13	SALTIMOR	
	APR 06 1993	grana David	AR'S SEMATURE	2								

DIVISION OF VITAL RECORDS, P.O. 108 ATENNING PHYSICIAN THE

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The Imm requires that the deserted the process within 24 hours after death. Page 6 may be retained by the host	be detache		IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	TATE OF MARYLAND	) / DEPARTI	MENT OF H	EALTH AND DEATH		GIENE G. NO.		017
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DE	ATH		ME OF DEATH
	ROBC D.	Oldland				монтн 4	3	93	6:45 AH
		SEX 6. AGE (In yrs.		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIF (Month, Day,		8. BIRTHPLACE Country)	(State or Foreign
		M 2 XF 97	YRS.			10/0	1/95	Maryl	and
Œ	9a. FACILITY NAME (If not institution, give street a	·	9		R LOCATION OF O		9c. COUN	TY OF DEATH	
DIRECTOR	Good Samaritan Hos	pital		Balti	more Cit	У		_	
EC	10a. STATE 10b. COUNTY		10c. CITY, 1	OWH OR LOCAT	ION	10d.	INSIDE CITY		
	Md. Balti	more	Par	kville					YES 2X NO
IAL	10e. STREET AND NUMBER			101.	ZIP CODE		10g. CITIZ	EN OF WHAT	OUNTRY?
FUNERAL	3004 Taylor Avenue				21234		U.	.S.A.	
J.	11, MARITAL STATUS 12.  1 Never Married 2 Married	WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2	ARMED	13. WAS DECI	ENDENT OF HISPA	NIC ORIGIN? (Spe	elfy Yes or No-	14. RACE - American Indian, Black, White, etc.	
ВУ	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE WAR OR DATES		1 TYES				Specify:	hite
	15. DECEDENT'S EDUCATIO	ON 16a.	DECEDENT'S US	UAL OCCUPATIO	N .	16b, KIND	OF BUSINESS/INDI		HILLE
Fi.	(Specify only highest grade comp	oleted)	(Give kind of world life. Do NOT use n	done during mos stired.)	at of working	100110110	0. 000		
P P	7 <b>T</b> H		Homemal	er					
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle,	Malden Surname)		
BE	Frederick W.	Sonn			Marie		Riley		
6	19a. INFORMANT'S NAME (Type/Print)						y or Town, State, Zip		
	Alameda R. Franc				le Rd.;	Baltimo	re, Md.	21234	
	20g METHOD OF DISPOSITION 1 ABurial 2 Cremation 3 Removal	from State 20b. PLA	CE AND DATE OF I	DISPOSITION (Na placs)	me of		20c. LOCATION C		-
	4 Donation 6 Other (Specify)	Parl	crematory or other		D ADDRESS OF FA	4/6	Baltimo	re Cit	У
	1/1/1/1	7			son Fune		ne.		
	ALL NI			8521	Loch Ra	ven Blv	d.; Balt	i., Md	. 21286
	23 PART I. Enter the diseases, or comp shock, or heart fellure. List	olications that caused the only one cause on each i	deeth. Do not line.	enter the mod	de of dyling, suc	h as cerdiec o	r respiratory arre		Approximete Interval Between
	IMMEDIATE CAUSE (Fine)			11.	/1				Onset and Death
	resulting in death) a	Ischemic Due to (or as a con	Lano	18 my	apouthy				
-		DUE TO (OR AS A CON	SECUENCE OF):						
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CON	SEOUENCE OF):						
CAT	cause. Enter UNDERLYING								
E	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CON	SEQUENCE OF):						
ERI	resulting in death) LAST								
AL C	PART II. Other significent conditions co	ntributing to deeth but no	ot resulting in 1	he underlying	cause given in	Part I 24e 3	MAS AN AUTOPSY	24h WERE	AUTOPSY FINDINGS
S	170			ne oneenjung	coupe given in	F	PERFORMED?	AVAILA	ABLE PRIOR TO LETION OF CAUSE
						- 10	YES 2 NO	OF DE	ATH?
Σ.								10	YES 2 NO
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL			28. PL	ACE OF DEATH (Ch	eck only one)			
Sic		SPITAL: Inpatient 2 - ER/Outpatient		THER:	5 - Residence		<b>(A</b> ()		
Ĕ	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME O	F 28c. INJU	PRY AT		HOW INJURY OCC	URED	
BY	1 Natural 5 Pending 2 Accident Investigation	(MOTER, Day, 10m)	INJUN	M 1 Y					
	3 Suicide 6 Could not be	28e. PLACE OF INJURY — At building, atc. (Specify)	home, farm, stre	t, factory, office		281. LOCATION	(Street and Number of	or Rural Route No	umber,
E I	4 Homicide detarmined						, 5000)		
COMPLETED	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN:	To the best of my knowledge,	death occurred a	t the time, data	and place, and due	to the cause(a) a	nd manner as atate	d.	
Ö	000) 2 MEDICAL EXAMINER: On	the besis of exemination and/	or investigation, i	n my opi <i>n</i> ion, de	ath occured at the	time, date and pl	aca, and dua to the	cause(a) and n	nanner as stated.
BEC	29b. SIGNATURE AND TITLE OF CERTIFIER	1. 1.1.			29c. LICENSE NUI	MBER	29d. DATE	SIGNED (Month	, Day, Year)
TO B	y-mohid -	Phylia	lh.		anager of the second		•	4/3/4	3.
F	30. NAME AND ADDRESS OF PERSON WHO COL	MPLETED CAUSE OF DEATH (	TEM 27) (Type, Pri	nt)			. /		11.
	Youse F MX		M.D	· , h	00000	aura	vi kay	Holl	ital.
	31. DATE FILED (Month, Day, Year)	22. REGISTRAR'S SIGNATURE	ndette.				,		
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IN THE FUNETAL DIRECTOR. ARE THE TAS CELLINGER INS CELLINGER INS CELLINGER INS CELLINGER DAY THE AREA SHOULD AND CHIMPERED TO THE THE THE THE THE THE THE THE THE THE
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STA	R TE GISTRAR	STATE OF M	ARYLAND /	DEPART ERTIFIC	MENT OF I	HEALTH DEAT	AND I	MENTAL	HYGIEN REG. NO	E	3	09618	
1. DECEDI	ELORES	Last)	P	OPE				2. DATE O	OF DEATH	7 (	73	3. TIME OF DEATH	
9a. FACILI	2. SOCIAL SECURITY NUMBER  2. S. SEX  5. SEX  6. AGE (In yrs. last birthday)  1. M 2. F  5. SEX  7. M 2. F  7. SEX  9. FACILITY NAME (If not institution, give street end number)					CITY, TOWN OR LOCATION OF DEATH					8. BIRTHPLACE (State or Foreign MARY LAND 9c. COUNTY OF DEATH		
RESIDE	SINAI HOSPITAL  RESIDENCE OF DECEDENT  10a. STATE  MARYLAND				BALTIM TOWN OR LOCA TIMORE		-		-			10d. INSIDE CITY LIMITS? 1 YES 2 NO	
10e. STRE	100. STREET AND NUMBER 4914 CHALGROVE AVENUE				10	2121		1			OF A	HAT COUNTRY?	
3 Wide	11. MARITAL STATUS  1 Never Married 2 Married 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES					CENOENT C	of HISPAI n, Mexico Specif	NIC ORIGIN? in, Puerto Ri y:	(Specify Yes	s or No—			
	Elementary/Secondary (0-12) College (1-4 or 5+) Illie. Do NOT u				rk done during m		VERSI		DUSTRY				
y	17. FATHER'S NAME (First, Middle, Last)  JAMES SEYMORE  19a. INFORMANT'S NAME (Type/Print)  MRS. MARGARET WIRTS  20a. METHOD OF DISPOSITION Burtel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LICENSEE  LEWIS T. GWYNN 2					18. MOTHER'S NAME (First, Middle, Maiden Surname) NETTIE VENEY							
200 METH 1X Burie 4 Done						MORIAL PARK 4/5/93 BALTIMORE, MAI					wn, State BALTO. RYLAND CO. 215-6393		
iMMEDi/ disease	T I. Enter the diseases, shock, or heart felice ATE CAUSE (Finel or condition p in death)	· Cf	Consed the decorate on each line of the DI A	70	ARN	ode of dy	ing, suc	h as cardi	ec or respi			Approximate interval Between Onset and Death	
if any, is cause. E CAUSE (	tielly list conditions, sading to immediate inter UNDERLYING (Disease or injury lated events g in death) LAST	· CA	OKLE OR AS A CONSEC OR AS A CONSEC	OUENCE OF):	WEPH	Au	100	KTHY	/				
PART II.	Other significent cond	litions contributing to o	leeth but not r	resulting in	the underlyin	g ceuse (	given in		24a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 211 NO	
EXAM 1 🗆 X	PER OF DEATH	HOSPITAL:	ER/Outpatient 3		OTHER:  Nursing Hor					NJURY OC	CURED	O.	
	o Codio no	28e, PLACE OF building, a	INJURY — At he		M 1 🗆	YES 2	NO		TION (Street of Town, State)		r or Rural R	loute Number,	

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BAT. MD SINAT 1993 SISIS F OT/STATE AVENUE
03/27/93 COLUBERG AARON 51512

03/27/93 COLI POPE DELORES 07881827-3086

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BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020	24 hours after death. Page 6 may be retained by the hospital or attending physician.	filled in by the funeral director, page 5 should be detached for use as the burial-trans on, or removal.	he medical examiner must be notified at once.
DIVIDION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OF NITEMENTS PRINCIPAL: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR-24for this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans be filed within 72 hours after death with the State Dept, of Meatta Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 • STATE REGISTRAR		STATE OF						MENTAL HY	GIENE	3	09619
- 1	1. DECEDENT'S NAME (First,	. Middle, Last)			CERTIF	ICALE	OF DEA	ТН	2. DATE OF DEA	NO.		3. TIME OF DEATH
- 3		W. PEA	ARCE						MONTH 04	DAY	1993	EAR
1	4. SOCIAL SECURITY NUMB		5. SEX	8. AGE (In yrs	s. lest birthday)	IF UNDER 1	YEAR IF UND	ER 24 HRS.	7. DATE OF BIRT	H	8.1	BIRTHPLACE (State or Foreign
	215-14-861		1X M 2 F							22 Maryland		
Œ	GREATER BA		,	T CENT	סשי		TOWN OR LOCA ISON	TION OF DE	EATH			OF DEATH
DIRECTOR	RESIDENCE OF DEC		VE PIEDICA	L CENT	LEK	10%	NOON				BALI	FIMORE
R	10e, STATE	10b. COUNT			10c. CIT	Y, TOWN OR	LOCATION					10d, INSIDE CITY LIMITS?
	MARYLAND	BAI	TIMORE		BA	LTIMO	RE					1 YES 2 NO
₹ I	10e. STREET AND NUMBER						10f, ZIP CO	DE		10g. (	CITIZEN	OF WHAT COUNTRY?
FUNERAL	7103 RICH	HILL F					212					U.S.A.
	11. MARITAL STATUS	Married		YES 2	□ NO	13. WA	AS DECENDENT yes, specify Cui	OF HISPAN	IIC ORIGIN? (Specin, Puerto Rican, e	ify Yea or No-	- 14.	RACE — American Indian, Black, White, etc.
BY	3 Widowed 4 Divo		MMII + K	OREA ORES	1	1 [	YES 2X N	Specify	y:		1	Specify: White
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MP					Presid	ent/ (	Owner		Plur	nbing	Con	tracting
COMPL	17. FATHER'S NAME (First, M.								ME (First, Middle, A			
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2	Georgia Mor		Donnes						Route Number, City			
	20a. METHOD OF DISPOSITI	ION	<del>-</del>	205 DI A				1. Ba	ltimore,		_	
	1 Buriel 2 Cremetion 3 Removed from State											
	4 Donation 5 Other (Specify) Green Mount Cemetery 04/05/98 Baltimore, Maryland  21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home							e, naryrand				
	Tohn C	Doite	z (M-0080	Stan	3/							7 1 04 04 0
	23. PART I, Enter the di				death. Do	ont enter th	000 101	K Ku	. Dalti	lore,	mar.	yland 21212
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	IMMEDIATE CAUSE (Fin disease or condition		Liet only one ceu	ise on each	lina.			ying, suc	h as cerdiec or	respiratory	errest,	
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MA !	6	8
( BAP	-	

filed within 72 hours after death  PORTANT: If Item 28 is ma  BE COMPLETED BY	100	ICIAN: To the best of my ki	nowledge, death occurre	ed at the time, o	date and place, and	due to the c		nner as stated.	ause(s) and	
death with the S  marked, or    BY PHYS	1 VES 2 NAO  27. MANNER OF DEATH  19 Netural 5 Pending 2 Accident Investigation	1 1 1 Inpetient 2 □ ER/C 28s. DATE DF INJU (Month, Day, Yes	RY 26b. TIM	E OF 28c.	INJURY AT WORK?  YES 2 NO		er (Specify)	NJURY OCCUI	RED	
with the State Dept. (ed, or Item 23 si	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	24-11-1 2 1 204	OTHER:	L PLACE OF DEATH					
MEDICA	PART II. Other algnificant condition	s contributing to deat	th but not resulting	In the underl	ying cause given	In Part I.	24a. WAS AN PERFOR 1 YES 2	IMED?	AMA COI OF	RE AUTOPSY FINDINGS ILLABLE PRIOR TO MPLETION OF CAUSE DEATH?  YES 2 XHO
Mental Hygiene prior to burial injury, or other traumatic	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	c. Persiste	AS A CONSEQUENCE OF	tative	state.					
al, cremation, event, the	IMMEDIATE CAUSE (Final disease or condition resulting in death)	Phe	AS A CONSEQUENCE O		ne Puln	wa	ry D-	- v seasi	0	Interval Between Onset and Death
or my gree unread or eater. page 5 should be detached or removal.  medical examiner must be notified at once.  TO BE COMPI	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Reduced.  24. HAME AND ADDRESS OF FACILITY 12, Ridgely Ave.  25. HAME AND ADDRESS OF FACILITY 12, Ridgely Ave.  26. Hame AND ADDRESS OF FACILITY 12, Ridgely Ave.  27. HAME AND ADDRESS OF FACILITY 12, Ridgely Ave.  28. HAME AND ADDRESS OF FACILITY 12, Ridgely Ave.  29. HAME AND ADDRESS OF FACILITY 12, Ridgely Ave.  21. HAME AND ADDRESS OF FACILITY 12, Ridgely Ave.  21. HAME AND ADDRESS OF FACILITY 12, Ridgely Ave.  22. HAME AND ADDRESS OF FACILITY 12, Ridgely Ave.  23. PART I. Enter the diseases, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Reduced.									
or must b	20e. METHOD OF DISPOSITION 1	oval from State	20b. PLACE AND DATE cemetery, cremetory or o MCLTO CT	emato	ry	l l	Bal	cation – ca ltimo	re,	MD
be notified  TO BE	Joseph Blevins				ne Ave.					21035
ed at once. BE COM	17. FATHER'S NAME (First, Middle, Last) John Page					name (First nkno	, Middle, Meiden WN	Sumame)		
ETE	15. DECEDENT'S EDU (Specify only highest grack Elementary/Secondary (0-12)		16a. DECEDENT'S (Give kind of interpretation of interpretation) (Printe	work done during se retired.)	ATION 7 most of working		<b>в. кию ог в</b> и Board			ving
as the buriatransit  D BY FUNER	11. MARITAL STATUS 1 Never Married 2 Married XXX Widowed 4 Divorced	12. WAS DECEDENT EVEN FORCES? 1X Y IF YES, GIVE WAR O	ES 2 NO	If yes	DECENDENT OF HIS , specify Cuben, Me YES 21 NO Sp	xican, Puerto		s or No.— 14	Bleck, W	American Indian, hite, etc. White
AL Permit	10e. STREET AND NUMBER  Vetera	ns Medica	1 Center		101. ZIP CODE 2 1 9 0 2					COUNTRY?
Pages	RESIDENCE OF DECEDENT  10a. STATE  MD  Cec	Υ	10c. CIT	y, TOWN OR LO		10001	100	1. INSIDE CITY LIMITS? YES 2¥ NO		
1, 2, 3 should	9e. FACILITY NAME (If not institution, give : Perry Point Ve		sp.		y Point			9c. COUNT		Н
2	4. SOCIAL SECURITY NUMBER 014-05-3333	1 X M 2 - F	GE (In yrs. lest birthdey) 92 YRS.	IF UNDER 1 YEA		(Mo	e OF BIRTH  oth, Day, Year)  -02-1		Country)	nce (State or Foreign
	Adelard Page					MON		1993	TEAR .	3:10 pm m
	REGISTRAR  1. DECEDENT'S NAME (First, Middle, Last)		CERTIF	ICATE C	F DEATH	_	REG. NO	<u> </u>		

CAUSE OF DEATH (ITEM 27) (Type, Print)

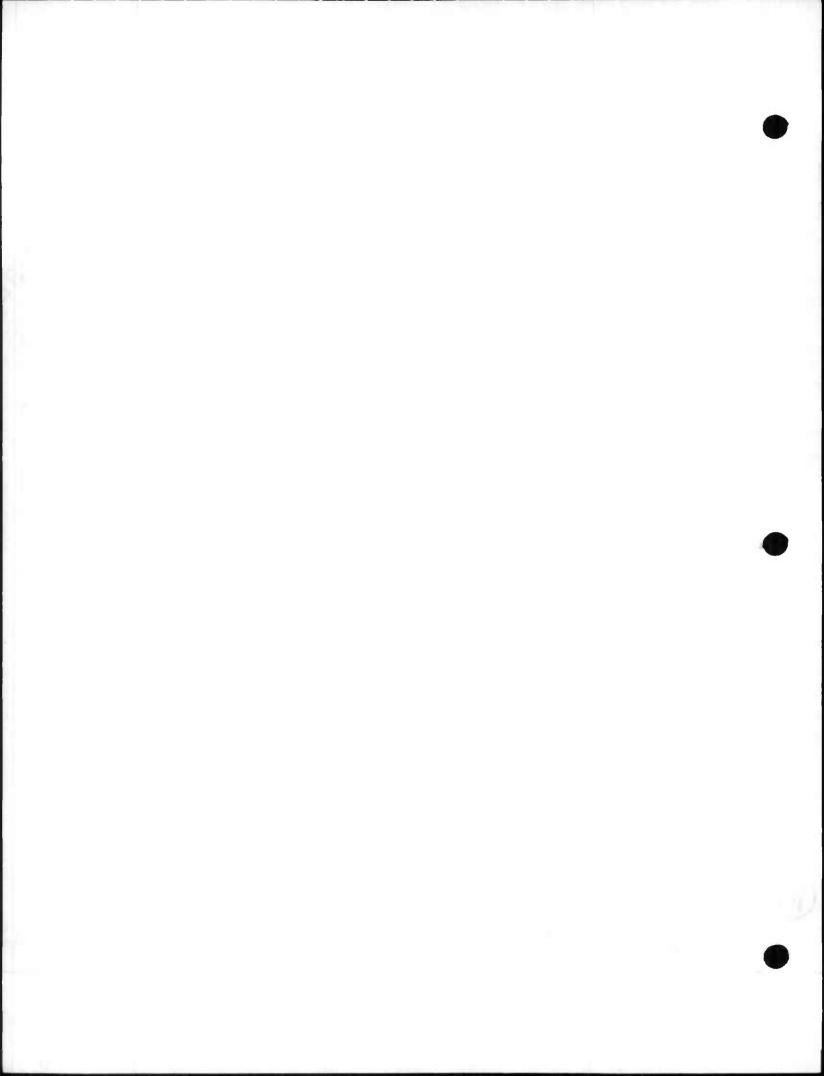
J., VAMC, PERRY POINT, MD.,

M.

APR 06 1993

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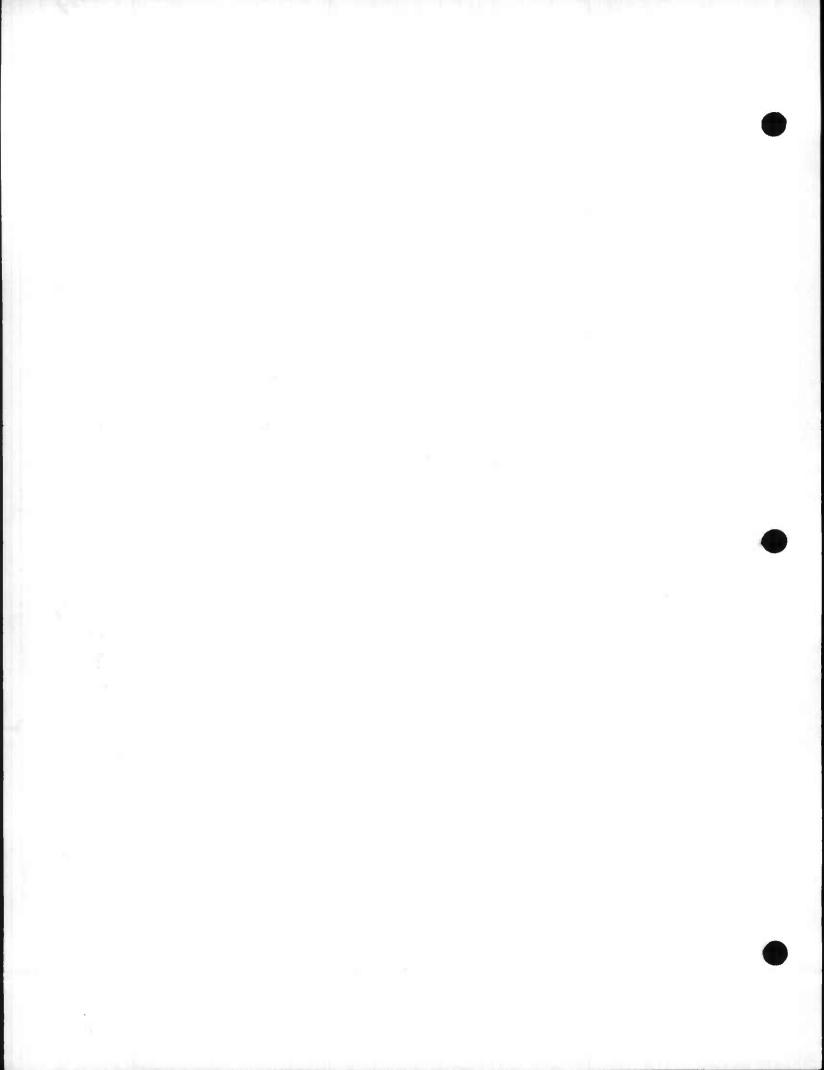


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		1002	00105 96735 A	Party	CTO	0					91	3 0	9621
	FOR STATE REGISTRAR	PER 10/3	STATE OF MAI	-	DEPAR	TMENT	OF H	EALTH AND	MENTAL	HYGIENI REG. NO.	_		7021
	1. DECEDENT'S NAME (	ICTOR	(3,43	ersi			SCU		2. DATE O		9	/EAR	TIME OF DEATH
	4. SOCIAL SECURITY N 097-38- 9a. FACILITY NAME (# //	1821	1 2 F	AGE (In yrs. lest	birthday) YRS.	IF UNDER	DAYS	IF UNDER 24 HRS. HOURS MIN.	Oct.	Day, Year)	947	Country) It	aly
TOR		s Scott	Key Hospit	cal		9b. CITY,		altimore			9c. COUNT	Y OF DEAT	н
DIRECTOR	Md.		ltimore		10c. CIT	Y, TOWN O		Sex					d. INSIDE CITY LIMITS?  YES 2 X NO
FUNERAL		, Marly						21221			Ü	N OF WHA	T COUNTRY?
BY FU	11. MARITAL STATUS 1 Never Married 2 3 Widowed 4	/ER IN U.S. ARI YES 2 NO OR DATES		14	yes, sp	ENDENT OF HISPAL ecify Cuban, Mexica 2 NO Specif	an, Puerto Ric		14. RACE — American Indian, Black, White, etc. Specify: White				
COMPLETED	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5 +)					usual oc work done do se retired.)	iring mo	st of working	16b. K		INESS/INDUS	STRY	
	12th 17. FATHER'S NAME (Fin Paol	ot, Middle, Last) O Persio	00			- Dep	ar u	18. MOTHER'S NA	AME (First, Mic	idle, Maiden S	imore	Sun	raper
TO BE	19a. INFORMANT'S NAME (Type/Print)  19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code  200 S.Birch Road Ft.Lauderdale Florid									da 3	3316		
	20s. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Committee Com												
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  ConnellyFuneralHome 300MaceAve. 21221												
IFICATION	immediate cause disease or condition resulting in death)  Sequentially list cor if any, leading to im	(Final	b	AS A CONSEO	UENCE OF	FI: POM	4	de of dying, suc	ch se cardie	oc or respir	ratory arres	it,	Approximate interval Betw Onset and De
CEMILLO	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):												
MEDICAL	PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I.    24a. WAS AN AUTOPSY PERFORMED?   1   YES 2   MO   WALLAND   1   YES 2   MO   1   YES 2   MO   1   YES 2   MO   1   YES 2   MO   1   YES 2   MO   1   YES 2   MO   YES 2   MO   YES 2   MO   YES 2   MO   YES 2   MO   YES 2   MO   YES 2   MO   YES 2   MO   YES 2   MO   YES 2   MO   YES 2   MO   YES 2   MO   YES 2   MO   YES 2   MO   YES 2   MO   YES 2   MO   YES 2   MO   YES 2   MO   YES 3										RE AUTOPSY FINDIN ILLABLE PRIOR TO MPLETION OF CAUS DEATH?		
PHYSICIAN:	25. WAS CASE REFERRE EXAMINER? 1 YES 2 NO		HOSPITAL:	/Outpatient 3	□ DOA	OTHER		ACE OF DEATH (Ch		Snacifu)			
DY PHY	27. MANNER OF DEATH  Netural 5  Accident	Pending Investigation	28s. DATE OF INJI (Month, Day, Y		28b. TIM		Bc. INJ			-	IJURY OCCU	RED	
	2 Accident 3 Sulcide 8 Could not be determined  28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  28f. LOCATION (Street and Number or Rural Poute Number, City or Town, State)									Number,			
COMPLE			ICIAN: To the bast of my										d manner as stated
O BE	29b. SIGNATURE AND T	MUSE	win					29c. LICENSE NUI	MBER		29d. DATE S	HIGNED (NO	3 93
	30. NAME AND ADDRESS  31. DATE FILED (Month, I	CKUM7	O COMPLETED CAUSE O	ept 1	1 Ped	NLIX	2	FSIC	494	10 5.	An	enere	Bothn
	APR	6 1993	Janu Duri	~	delle								(DA

BALTIMORE, MARYLAND 21215-0020

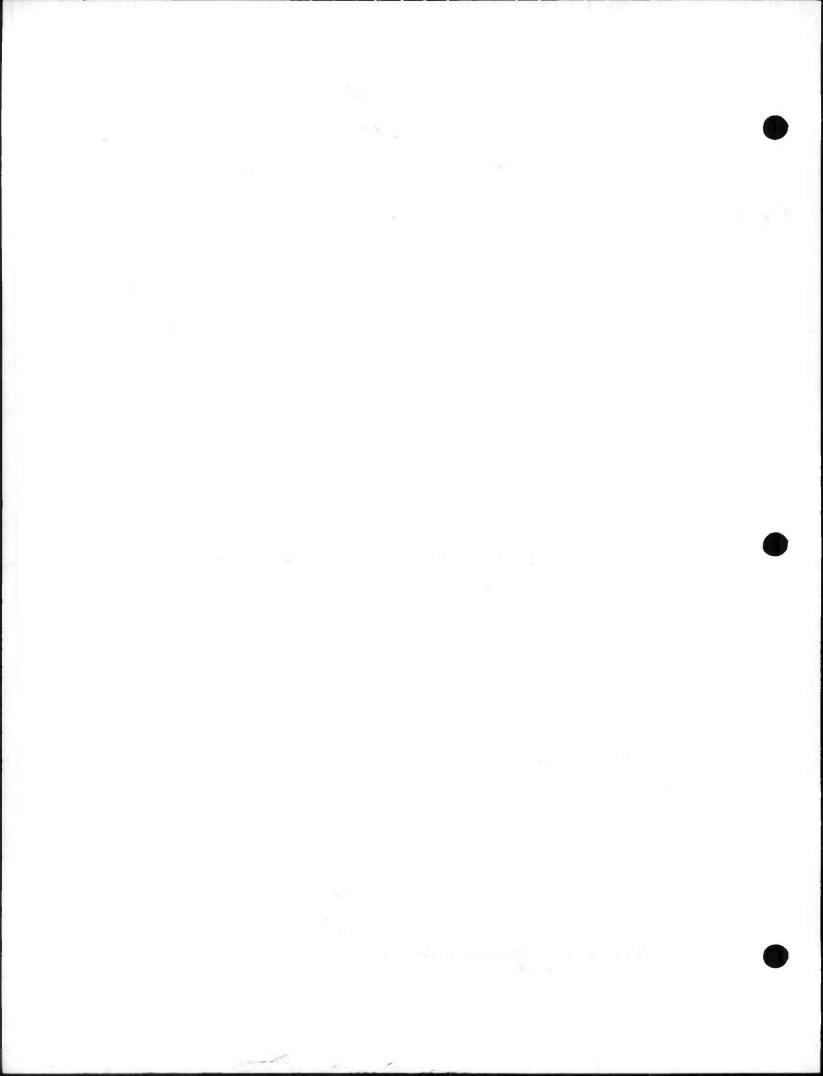
DIVISION OF VITAL RECORDS, P.O. BOX 68760,



BALTIMORE, MARYLAND 21215-0020	4 hours after death. Page 6 may be retained by the hospital or attending physician.	filled in by the funeral director, page 5 should be detached for use as the burlal-transit page, or removal.	re medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit abe filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

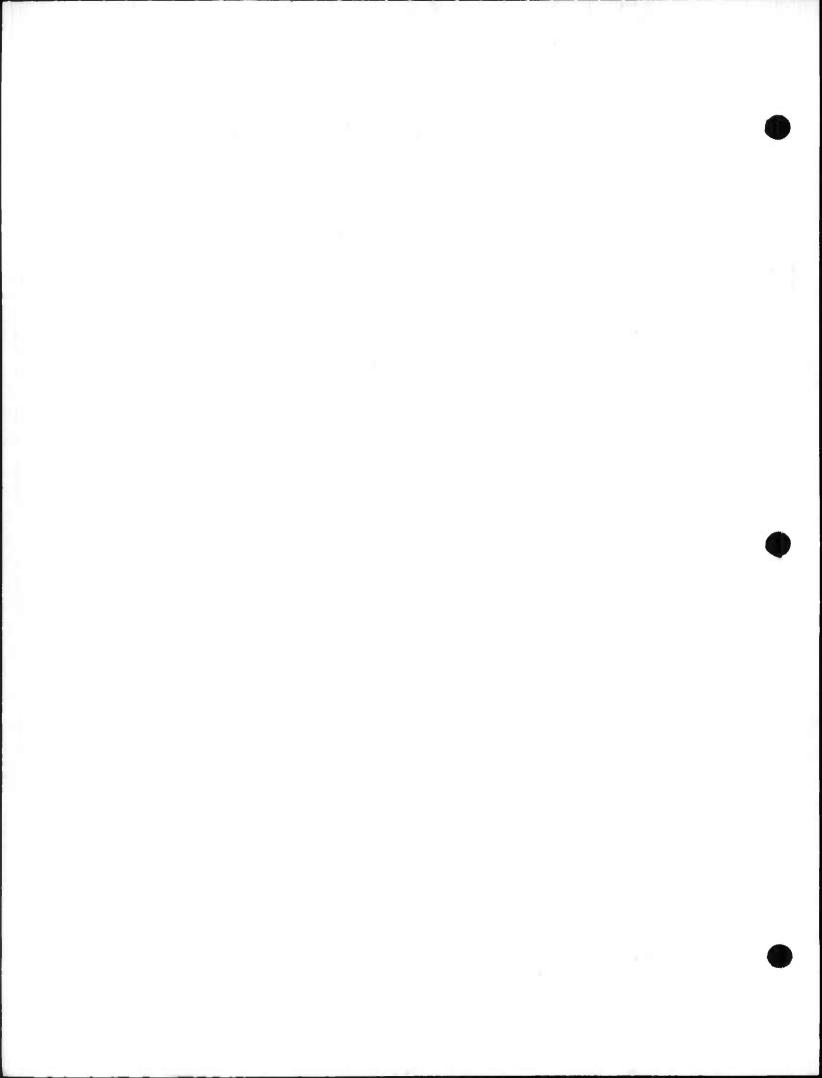
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

	1. DECEDENT'S NAME (First, Middle, Last)  TEAN (JEAN ROSEN) ROSEN  2. DATE OF DEATH MARCH 31, AV 1993 YEAR 6: 24 (P)													
	TEAL	156	SEN				MARCH 31, 1993 YEAR			6:24 (P )				
				6. AGE (In yrs. la	st birthday)	IF UNDE			1 24 HRS.	7. DATE OF	BIRTH			PLACE (State or Foreign
	218-12-46		1 🗆 M 2 💢	71	YRS.	MONTHS	DAYS	DAYS HOURS MIN. (Morth, Day, Year)					MAI	YLAND
	90. FACILITY NAME (If not in					600		OR LOCAT				9c. COU	NTY OF D	
6	BALTIMORE		GENERA	HOSPIT	'AL	RANDALLSTOWN BAL						BALT	TIMORE	
<u> </u>	RESIDENCE OF DEC	10b. COUNTY	,		10c, CIT	Y, TOWN	OR LOCAT	TION						10d. INSIDE CITY
DIRECTOR	MARYLAND				BAI	LTIM	ORE						- 1	LIMITS?
	10e. STREET AND NUMBER						101	. ZIP COD	E			10g. CIT	IZEN OF W	HAT COUNTRY?
ER.	3100 BANCE	ROFT RI	O, APT. A	A					2121	5			US	SA
FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. A	BMED					NIC ORIGIN?		or No-	14. RACE	- American Indian,
PY	1 Never Married 2 2 3 Wildowed 4 Divo		IF YES, GIVE		NO			24 NO		n, Puerto Ric Y	en, etc.)		Specif	, White, etc.  V: WHITE
		EDENT'S EDUC	CATION	140.0	ECEDENT'S	1101111 0	00/10/21/	201						WILLE
COMPLETED		highest grade	completed)		Sive kind of a	work done			ng	16b, K	INO OF BU	SINESS/IN	DUSTRY	
7	12	-12)	College (1-4 or 5	"	SECRI	ETAR	Y			S'	TATE	OF M	ARYLA	AND
O	17. FATHER'S NAME (First, M	iddle, Last)						18. MOT	HER'S NA	ME (First, Mic	idle, Maiden	Sumame)		
BE C	ABRAHAM AI	ELMAN							NORM	A HAR	TMAN			
10	19a. INFORMANT'S NAME (7	i/pe/Print)	-	11	b. MAILING	ADDRES	S (Street a	and Numbe	r or Rural i	Route Number	City or Tow	n, State, Zij	Code)	
٦	MR EDWIN F				3100	BAN	CROF	T RD	.,AP	T. A	BALTI	MORE	, MD	21215
	20a. METHOD OF DISPOSITI	n 3 🗆 Remo	oval from State	20b. PLACE					7 TM )	4-4-9	20c. LO	CATION -	City or To	wn, State
	4 Donation 5 Other  21. SIGNATURE OK FUNERA		ENSEE A	ANSII	- ENIO	NAII	(ATT	Z CII	ATIT)	4-4-9	DAL	TINO	RE, I	שה
	▶ ( la	no.	4	`						N & B				
	23. PART . Enter the d	Mu	MILL											E, MD 21215
	SHOCK, OF I	part fellure.	List only one cer	ise on each lin	eath. Do i e.	not enter	the mo	ide of dy	ing, suc	h aa cardia	c or respi	Iratory an	rest,	Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition INTERACE DEPORAL HEMOROHACE													
	disease or condition— resulting in death)  a. INTRACEREBRAL HEMORRHAGE  DUE TO (OR AS A CONSEQUENCE OF):													
z	- HYPERTENICIONI													
CERTIFICATION	If any, leading to immediate DUE TO (OR AS A CONSCOUENCE OF):													
윤	CAUSE (Disease or Injury C. DUE TO (OR AS A CONSEQUENCE OF):													
E	resulting in death) LAS	т		(0.1.10.1.00.100.	O LIVEL O	,.	İ						į	
	DAST II Other significant conditions contributes to death to													
MEDICAL	PERFORMED? AM								WERE AUTOPSY FINDINGS MAILABLE PRIOR TO					
										COMPLETION OF CAUSE OF DEATH?				
ac. 11	1 YES 2 NO									1 YES 2 NO				
AN	25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)													
PHYSICIAN:	EXAMINER?		HOSPITAL:	ER/Outpatient	DOA	OTHE	R:			6 🗆 Other (	Specifyl			
žΙ	27. MANNER OF DEATH		28a. DATE OF (Month, E	INJURY	28b. TIM	E OF	28c. INJ	URY AT			RIBE HOW I	NJURY OC	CURED	
BY F		Pending Investigation	(Month, E	wy, rour)	l les	URY M		YES 2	] NO					
								•				and Number	or Rural R	oute Number,
			burranny,							,	City or Town, State)			
ETED	4 Homicide	determined	Donality,											
APLETED	4 Homicide  29e. CERTIFIER (Check only	SET SET SET SET SET SET SET SET SET SET	CIAN: To the best of											
COMPLETED	4 Homicide  29e. CERTIFIER (Check only	SET SET SET SET SET SET SET SET SET SET	CIAN: To the best of	xamination and/or	Investigatio	n, in my o	opinion, d							and manner as stated.
	4 Homicide  29e. CERTIFIER (Check only	Setermined  IFYING PHYSIC  CAL EXAMINE	CIAN: To the best of e	xamination and/or	Investigatio	n, in my o	opinion, d	eath occu		time, date ar		d due to th	ne cause(s)	and manner as stated.
H H	29e. CERTIFIER (Check only one) 29 MEDI	IFYING PHYSIC CAL EXAMINEI OF CERTIFIER	CIAN: To the best of R: On the basic of e	xamination and/or	Investigation  US  YYS	en, in my o	AN	29c, LIC	red at the	time, date an	nd place, an	d due to th	ne cause(s)	
TO BE COMPLETED	29e. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE 30. NAME AND ADDRESS OF	OF CERTIFIER PERSON WHO	CIAN: To the best of R: On the basic of e	SE OF DEATH (ITE	Investigation  US  YYS	en, in my o	AN	29c, LIC	red at the	time, date an	nd place, an	d due to th	ne cause(s)	
H H	29e. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE 30. NAME AND ADDRESS OF	OF CERTIFIER PERSON WHO	CIAN: To the best of a city of a cit	SE OF DEATH (ITE	Investigation  S  Y  S  M  27) (Type,	E (C t) Print)	AN	29c, LIC	red at the	time, date ar	nd place, an	d due to th	ne cause(s)	



000-	ling president.	the burn and mit. Pages 1, 2, 3 should	
BALTIMORE, MARYLAND 21215-0000	death. Page 6 may be retained by the hospital or atten	funeral director, page 5 should be detached for use at	xaminer must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	**O THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending previous	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the number of the nu	MPORTANT: if Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR		CATE OF		REG. NO	_					
	1. OECEDENT'S NAME (First, Middle, Last) BLANCHE S	SNYDER	RYMLAND		2. DATE OF DEATH		3. TIME OF DEATH 2:30 PM M				
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. 213–28–4758	10 42 0 5			7. DATE OF BIRTH (Month, Day, Year) SEPT. 1,19	6.	BIRTHPLACE (State or Foreign Country) W YORK				
TOR	9a. FACILITY NAME (If not institution, give street and number)  ACCO N. CHARLES ST. APT. 404  RESIDENCE OF DECEDENT			TIMORE	EATH	9c. COUNTY	OF DEATH				
DIRECTOR	10a. STATE 10b. COUNTY MARYLAND	10c. CITY	, TOWN OR LOCAT	TIMORE		10d. INSIGE XXIMITS? 1 XYES 2					
FUNERAL	4000 N. CHARLES ST, APT. 404		101	ZIP CODE	.218	10g. CITIZEN OF WHAT COUNTRY?  USA					
B	11. MARITAL STATUS  1 Never Married 2 Married  3 Wildowed 4 XXV vorced  12. WAS DECEDENT EVER IN U.S. FORCES? 1 VES 2 IF YES, GIVE WAR OR DATES	NO	13. WAS OEC If yes, sp 1 YES	RACE — American Indien, Black, Whita, atc. Specify: WHITE							
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  A	(Give kind of w life. Do NOT us	USUAL OCCUPATION ork done during more retired.)	st of working	16b. KIND OF BUS	SINESS/INDUST	TRY				
MO	17. FATHER'S NAME (First, Middle, Last) SOLOMON SNYDER	1102			ME (First, Middle, Maiden	Cumama!					
BE	SOLOMON SNYDER  199. INFORMANT'S NAME (Type/Print)	10h MAU INC	ADDRESS (Change)		( UNKNOW	N)					
5	MR RICHARD S. RYMLAND	3917	WATSON	PLACE NW	WASHING		.C. 20016				
	20a. METHOD OF DISPOSITION  1 Burdel 2 Tremation 3 Removal from State  20b. PLACE AND DATE Of DISPOSITION (Name of Commetter) Commetters of Commetters Commetters Commett										
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	,	SOL LE		BROS IN		4D 21215				
	23. PART   Enter the diseases, or complications that ceused the shock, or heart fellure. List only one cause on each is IMMEDIATE CAUSE (Final disease or condition	iina.	ot enter the mo	de of dying, sucl	h as cardlec or reapi	ratory arrest,	Approximate interval Between Onset and Death				
	disease or condition a. A CUTE MYOCARMIL INFARCTION INFARCTION INFARCTION INFARCTION										
CATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING										
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST										
	PART II. Other eignificant conditions contributing to death but no	ot reaulting is	the underlying	Cause given in	Part I. 24a. WAS AN	Alemoney	ACL METER ALTERNAL THROUGH				
DICAL	Berile Der			cansa divan in	PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE				
BY PHYSICIAN: MED					1  YES 2	E NO	OF DEATH?  1 YES 2 NO				
S	25. WAS CASE BEFERRED TO MEDICAL EXAMINER? HOSPITAL:			ACE OF DEATH (Che	ick only one)						
YSI	1 PYES 2 NO t □ inpetlant 2 PER/Outpatient	3 🗆 DOA	OTHER: 4 - Nursing Hom	5 Desidence	6 Other (Specify)						
ВУ РН	27. MANNER OF DEATH  1 Netural 5 Pending 2 Accident Investigation  26a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	M 1 Y	25 2 NO	28d. DESCRIBE HOW II	NJURY OCCURE	:D				
	3 Suicide 8 Could not be detarmined 26s. PLACE OF INJURY — At building, atc. (Specify)	home, farm, at	reet, factory, office		281. LOCATION (Street a City or Town, State)	nd Number or R	urai Route Number,				
COMPLETED	29a. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of my knowledge, one)  2 MEDICAL EXAMINER: On the basis of examination and/o						use(a) and manner as stated.				
BE	29b. SIGNATURE AND TITLE OF CERTIFIES			29c. LICENSE NUM	18ER	29d. DATE SIG	GNED (Month, Day, Year)				
٩	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (I	_	Print) BERS 700	390	GREKN	SPEIN	RI 1993				
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE		00000	1	10. d	1211					
	APR - 6 1993 Julie Tevidon 1	andelle.									



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1 - FOH STATE REGISTRAR 09624 93 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATN MELEN REED A. MONTH Helen A. Reed 205 3 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH 09/08/1911 IF UNDER 1 YEAR IF UNDER 24 HRS 217-12-1285 8 DAYS HOURS COHOLLA) 1 M 2 M 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Harbor Hospital Center DIRECTOR Baltimore Baltimore RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Baltimore Baltimore 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 7315 Betz-Avenue 21219 U.S.A. 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No H was sneetly Cuban, Mexican, Puerto Rican, etc.) 11 MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuban, Mexican, P

1 YES 2 NO Specify: BY Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker 12 Years 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Herbert John Hipsley Emma Amelia Yakel BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Kevin Reed 7315 Betz Avenue Baltimore MD 21219 20a, METHOD OF DISPOSITION
1 M Surial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE Springrelld Cemetary 4/7/93 Sykesville MD 22-NAME AND ADDRESS OF FACILITY Dippel Funeral Home 21. SIGNATURE OF FUNERAL SERVICE LICENSEE rarilon Baltimore MD 21206 23. PART I. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate ahock, or haart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition PNEUMONIA reaulting in death) DUE TO (OR AS A CONSEDUENCE OF): LEBRO VASCULAR ACCIDENT PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE DF): cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (DR AS A CONSEDUENCE OF): that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO TRACT INFECTION COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO A20TEMIA 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) EXAMINER? HOSPITAL: OTHER: 1 Chipatient 2 ER/Outpatient 3 DOA me 5 Residence 6 Other (Specify) 4 Numing Ho 27. MANNEB-OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DEŞCRIBE NOW INJURY OCCURED 1 Natural 5 Pending BY 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — Al home, farm, street, factory, offica building, etc. (Specify) 3 Sulcide 8 Could not be 281. LOCATION (Street and Number or Flural Floute Number, City or Town, State) COMPLETED 29a, CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, 296 SIGNATURE AND TITLE OF CENTIFIER 29d. DATE SIGNED (Monthy Day. ungal smill sandha house officer

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

WE HALS. SANDHA, MANDER KUSH, CENTER, 3007 S. HANOVER ST. 322 EGISTRAR'S CONATURE
THE Day doon - Handele

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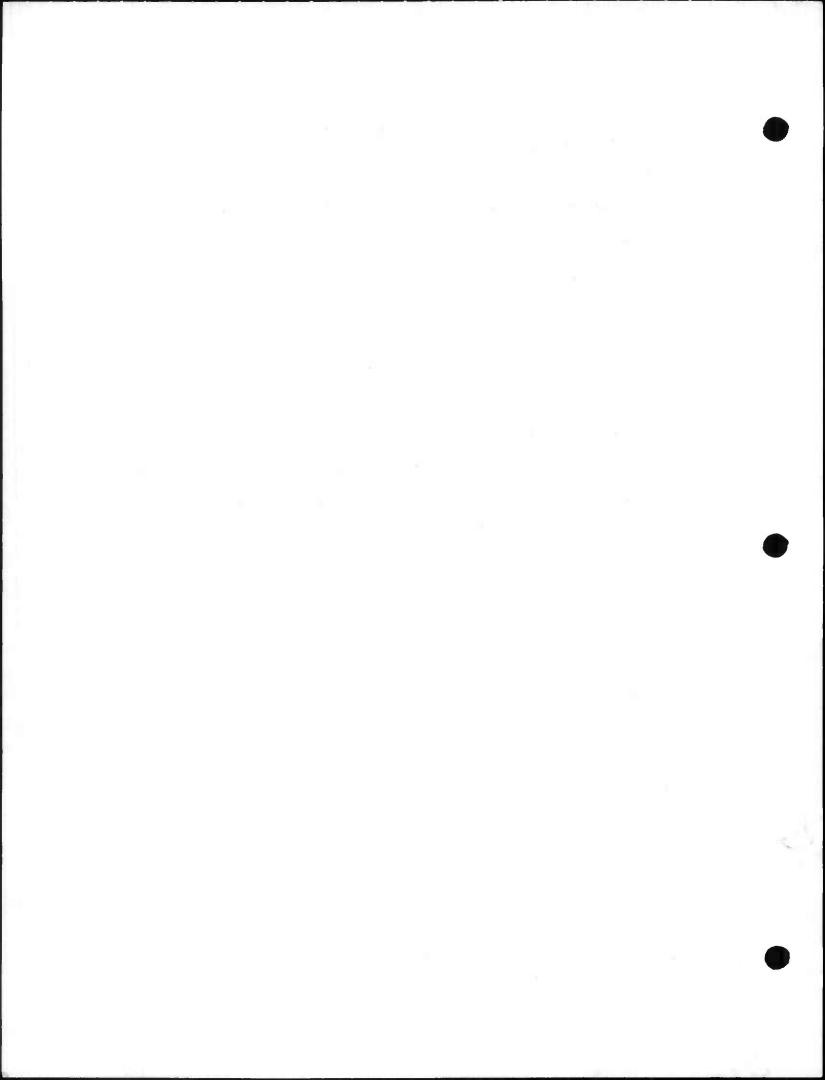
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BALTIMORE, MARYLAND 21215-0020	SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	IERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permi in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
3760,	ted within 24	IERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
DMINON OF VITAL RECORDS, P.O. BOX 68760,	cate be execu	hysician and prior to bur
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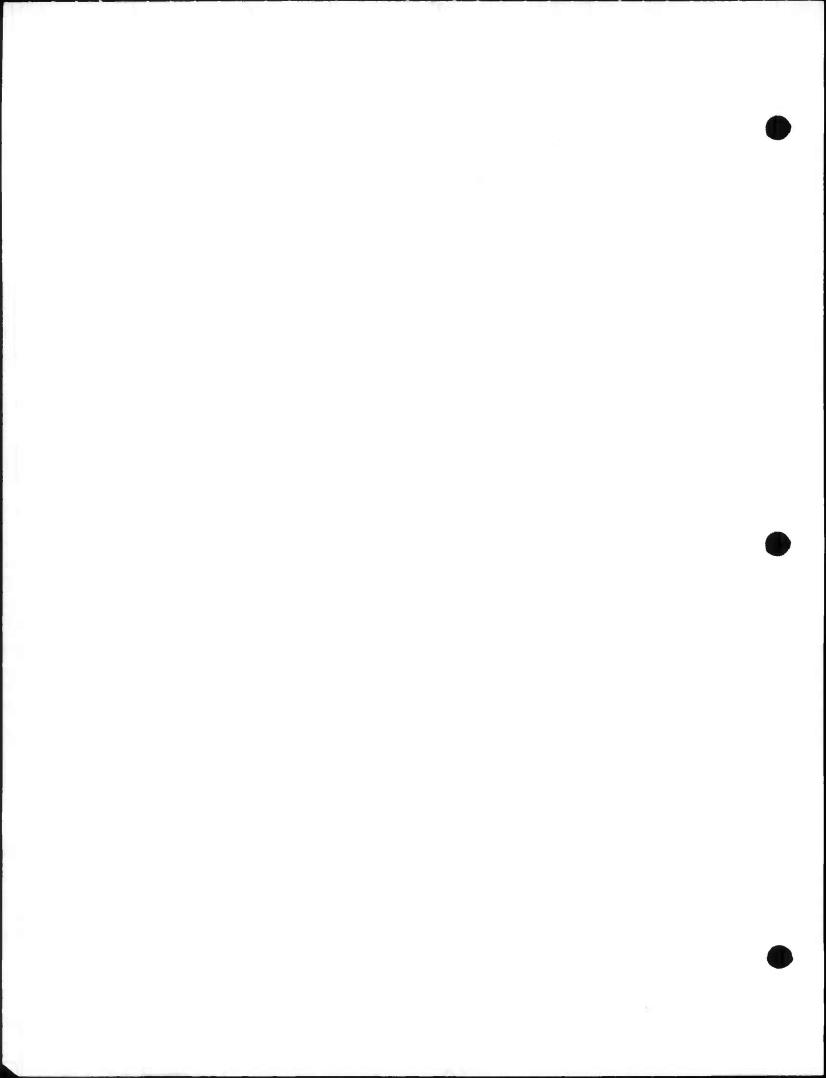
STATE OF MARYLAND	DEPARTMENT	OF HEALTH	AND	MENTAL	HYGIENE
C	ERTIFICATE	OF DEAT	TH		REG NO

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAN		TMENT OF H		MENTA	L HYGIEN REG. NO.	E	03023	
	1. OECEOENT'S NAME (First, Middle, Last)  Ruth Shoemal	RUTH L. SHOEMAKER			2	2. DATE OF DEATH DA			3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 212-22-1093	5. SEX 8. AGE (In y)	IF UNDER 1 YEAR MONTHS DAYS			7. DATE OF BIRTN (Month, Day, Year) 1/12/1904		BIRTNPLACE (State or Foreign Country)     Maryland		
TOR	96. FACILITY NAME (If not institution, give street and number)  Union Memorial Hospital  Baltimore Maryland  RESIDENCE OF DECEDENT									
DIRECTOR	10e. STATE 10b. COUNTY			town on Local					10d. INSIDE CITY LIMITS?  1 X YES 2 NO	
FUNERAL	100. STREET AND NUMBER 4809 Crosswood	Ave.		101. ZIP CODE 21214				S.A.		
ВУ	11. MARITAL STATUS  1 Never Married 2 Married  3 Wildowed 4 Divorced  12. WAS DECEDENT EYER IN U.S. AR FORCES? 1 YES 2 X IF YES, GIVE WAR OR DATES			13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea If yea, specify Cuban, Mexican, Puerto Rican, etc.)  1  YES 2  NO Specify:						
PLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)		(Give kind of w life. Do NOT us	,		161	o. KIND OF BUS	IND OF BUSINESS/INDUSTRY		
COMPL	17. FATHER'S NAME (First, Middle, Lust) Theodore		House	WILE		AME (First, Middle, Meiden Surname)				
TO BE	19e. INFORMANT'S NAME (Type/Print)	MANT'S NAME (Type/Print)			and Number or Rural Route Number, City or Town, State, Zip Code)					
	Mrs. Jean S. Port  20a. METHOD OF DISPOSITION 1 M Burlel 2 Cremation 3 Remo	20b. PL	ACE AND DATE O	F DISPOSITION (Na		OAT	E 20c. LO	CATION — City	1093 or Town, State	
	Hampstead Cem. 4/7/93   Hampstead MD  21. SIGNATURE OF FUNERAL SERVICE LICENSEE Paul L. Hartsock, Jr.  Paul L. Hartsock, Jr.  Leonard J. Ruck, Inc. 5305 Harford Rd.									
CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted evente resulting in death) LAST  Conset and Death Cause (Final disease or conditions).  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):									
MEDICAL	PART II. Other algorificant conditions  CONGESTIVE F  CONGESTIVE F  TURNIN DIFFE		ng cause given in Part I. 24a. WAS AI PERFO			MEO?	AWAILABLE PRIOR TO			
SICIAN:	TUSULO DEFICACE D'ABOTES HELLETS  25. WAS CASE REFERRED TO MEDICAL  EXAMINER?  1 YES 2 NO  1 Inpetient 2 ER/Outpetlent 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)									
ву РНҮ	27. MANNER OF DEATN  1  Netural 5 Pending 2 Accident Investigation	MANNER OF DEATN    28e. DATE OF INJURY (Month, Day, Year)			URY AT HRK?	6 U Other (Specify)  28d. DESCRIBE HOW INJURY OCCURED			ED	
TED	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — j building, etc. (Specify)	reet, factory, offic	, office 2		281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
COMPLET	29e. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end menner as stated.  2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner as stated.									
TO BE COM	296. SIGNATURE AND TITLE OF CERTIFIER  JULY 10 10 10 10 10 10 10 10 10 10 10 10 10				29c. LICENSE NUMBER  29d. OATE SIGNED  0 4			GNED (Month, Day, Year)		
	nin:		745T C		ry PA	Rhh	ny K	BALM	nare his	



BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	EMECTION Affice has been signed by the attending physician and completely filled in by the funeral director bane 5 should be detached for use as the burial-transfer narmit banes 1 2 about	, or removal,	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	ANTHAL ARE LAW requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	HETTON ATTLEMENT INCOME has been signed by the attending physician and completely fill	ins many and the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal,	item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	_	1 - FOR STATE REGISTRAR	STATE OF M	ARYLAI	ND / DEPAR	RTMENT	OF HEALTH A	ND ME	NTAL HYGIEN					
		,	DECEDENT'S NAME (First, Middle, Lest)  William C. Smith						2. DATE OF DEATH MONTH 4 / 2 / 1993 6:10 P M					
		4. SOCIAL SECURITY NUMBER		6. AGE (In	yrs. last birthday)	IF UNDER 1	EAR IF UNDER 24	HRS. 7.	DATE OF BIRTH	1.0	BIRTHPLACE	E (State or Fo	M preian	
2, 3 should		214 44 9548	1 🔀 M 2 🗆 F	46	6 YRS.		0.000	MIN,	11/24/46	5	Maryl			
	стоя	9a. FACILITY NAME (If not institution, give street and number)  6 Holly Road  9b. CITY, TOWN OR LOCATION Pasadena							sc. county of Death Anne Arundel					
\$	ECT	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d INSIDE CITY												
d by the hospital or attending physician. Id be defacthed for use as the burial-transit permit. Pages 1, d at once.	DIR	Maryland A	ryland Anne Arundel P						10d, INSIDE CITY LIMITS? 1 YES 2 KNO					
	FUNERAL	6 Holly Road				10f. ZIP CODE 21122				10g. CITIZEN	OF WHAT O	COUNTRY?		
	B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 [ IF YES, GIVE WA Viet Nat	2 NO	MED  13. WAS DECENDENT OF NISPANI If yea, specify Cuban, Maxican 1 YES 2 NO Specify:			ORIGIN? (Specify Yes tuerto Rican, etc.)	or No.— 14.	14. RACE — American Indian, Black, White, atc. Specify: White		ın,		
	COMPLETED	15. DECEDENT'S E (Specify only highest gra Elementary/Secondary (0-12)	(Given the distribution of			CEDENT'S USUAL OCCUPATION the kind of work done during most of working Do NOT use retired.)  LIPETVISOR			Baltimore Gas & Electric					
	BE COI	Jeremiah Smith						Vera	NAME (First, Middle, Meiden Surname) era Keimig					
ay be retained page 5 should the notified	5	19a. INFORMANT'S NAME (Type/Print)  Karen Salvaro:	la			ADDRESS (S			o Number, City or Tow adena, Ma			22		
pe 6 may rector, pag must b		20a. METNOD OF DISPOSITION 1	amoval from State	20b.Pi	ACE AND DATE	of disposition of the place Me	Morial P	ark	DATE 20c. LO 4/6 Ba	cation - chy ltimore			d	
s after death. Page 6 m by the funeral director, emoval.		22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225												
within 24 hours operation, or n cremation, or n		23. PART I. Enter the diseases, or complications that caused the daeth. Do not enter the mode of dying, such as cardisc or respiratory arrest, shock, or heart failure. List only one ceuse on sech line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Due To (OR AS A CONSEQUENCE OF):												
ysician prior to	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):												
e death certificate the attending physic Mental Hygiene pri Jury, or other to	CERT	resulting in death) LAST												
N. The law requires that the deal ficate has been signed by the att State Dept. of Health and Menta Item 23 shows any injury,	MEDICAL	PART II. Other significant condition	ons contributing to d	leath but	not resulting	n the unde	rlying cause give	en in Per	t i. 24a. WAS AN PERFOR	MED?	COMPI OF DE	AUTOPSY FII ABLE PRIOR T LETION OF C EATH? YES 2 N	TO AUSE	
has beer Dept. of	z l									1		169 2	~	
AN: The I	SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER:	8. PLACE OF DEAT							
TAT	PHYSICIAN:	27. MANNER OF DEATN  1 Neturel 5 Pending	26a. DATE OF III	NJURY	28b. TIM	E OF 28 URY	Home 5 Reside	284	Other (Specify)	NJURY OCCURE	D		$\dashv$	
	red BY	2 Accident Investigation 3 Suicide 8 Could not b 4 Homicide determined	28e, PLACE OF	INJURY — Ic. (Specify)	Al home, ferm, s		YES 2 N		LOCATION (Street a City or Town, State)	and Number or R	ıral Route N	umber,		
PITAL OR ATTE PAL DIRECTO 72 hours after 5: If Hern 28	COMPLETED	29a. CERTIFIER (Check only one)  1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and dua to the cause(a) and manner as stated.  2 MEDICAL EXAMINER: On the best of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(a) and manner as stated.												
TO THE HOSPITAL ( TO THE FLANERAL D De filed within 72 in IMPORTANT: If in	BE CO	29b. SIGNATURE AND TITLE OF CERTIFIER  SERVINATION OF SIGNED (Month, Dev. Year)  29c. LICENSE NUMBER  29d. DATE SIGNED (Month, Dev. Year)												
P P 2 \$	2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typ), Print)												
		31. DATE FILED (Month, Day Year)	A 320 RECIETDAM	CEICHATI	IDE									
		APR 06 1993	chia Davidson	Aunda	6E									



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BALTIMORE, MARYLAND 21215-0020	e executed within 24 hours after death. Page 6 may be retained by the hospital or attending physici	an and completely filled in by the funeral director, page 5 should be detached for use as the burial-t
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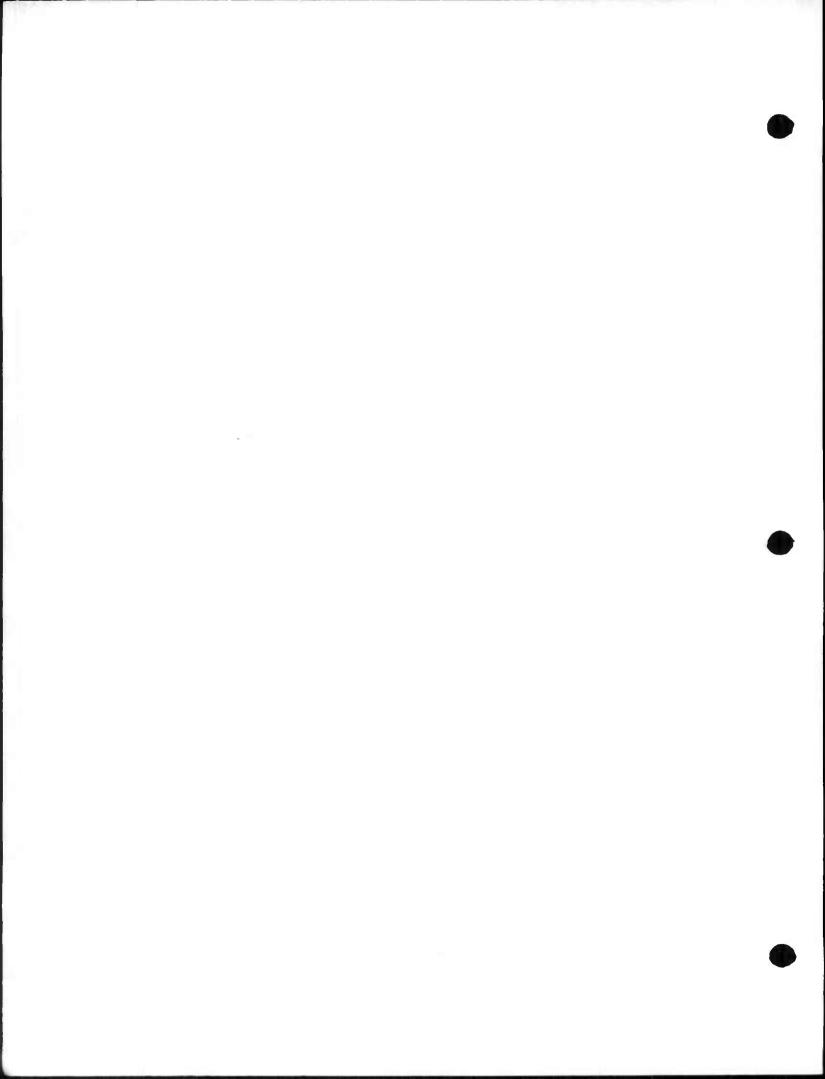
			1 - STATE STATE REGISTRAR	OF MARYLAND	/ DEPARTME	NT OF HEALTH AI	ND MENTAI	HYGIENE REG. NO.		
		33	1. DECEDENT'S NAME (First, Middle, Last)					OF DEATH	YEAR	3. TIME OF DEATH
			JOAN SECON  4. SOCIAL SECURITY NUMBER  5. SEX				3	3	1993	9:25 AH
3	3	9	218 26 3135 1 □ M 2		YRS. MONT		(Month 8/5	0F BIRTH 1. Day, Year) /1930	Country	PLACE (State or Foreign ) NSYlvania
2 a ebould	ű	DIRECTOR	9a. FACILITY NAME (If not institution, give street and num Harbor Hospital Cen			altimore	City		COUNTY OF DE	
-	3	EC	RESIDENCE OF DECEDENT  10a, STATE  10b, COUNTY		10c. CITY, TOW	/N OR LOCATION				10d. INSIDE CITY
2		. (.)	Maryland Anne Aru	ndel	Balti	more		-		LIMITS?
an.		FUNERAL	5201 Disney Avenue			21225	5	100	U.S.A.	
-AND 21215-0020 The hospital or attending physician: deached for use as the burial-transit norm? Panes 1		B≼	1 Never Married 2 K Married FORCE	CEDENT EVER IN U.S. A S? 1 1 YES 2 18 GIVE WAR OR DATES		13. WAS DECENDENT OF H If yes, specify Cuban, N 1  YES 2 NO	IISPANIC ORIGIN laxican, Puerto F Specify:	? (Specify Yes or N lican, atc.)		- American Indian, White, atc.
1215 r attend		Œ	15. DECEDENT'S EDUCATION (Specify only highest grade completed)		DECEDENT'S USUAL	one during most of working	16b.	KIND OF BUSINES	SS/INDUSTRY	
AND 21 he hospital or	3	COMPLET	Elementary/Secondary (0-12) College (1 12th Grade	4 or 5 +)	Me. Do NOT use retire	d.)		Bowling	Alley	
/LAN y the h			17. FATHER'S NAME (First, Middle, Lest) Ammon	Schaeffe	×			fiddle, Malden Sume		
MARYLAND retained by the hospit 5 should be deached	notified a	BE	19a. INFORMANT'S NAME (Type/Print)			ESS (Street and Number or I		ite Perz		
	be no	2	Ralph Secoura		5201 Di	sney Avenue	Balt	imore, 1	Marylan	
O m efor	r must		1X Burial 2 Cremation 3 Removal from S 4 Donation 5 Other (Specify)		CLOSS	emetery	4/3	Balti		Maryland
BALTIMORE, after death. Page 6 may be w the funeral director, page	al. examiner		21. SIGNATURE OF FUNERAL SERVICE LICENSEE  PLOOME FOR	neiourt		<sup>22.</sup> NAME AND ADDRESS G George J. G 4001 Ritchi				. 21225
a a	E 3		23. PART i. Enter the diseases, or complication shock, or heart failure. List only o	ns that caused the	death. Do not en	tar the mode of dying,	such as card	lac or respirator	ry arreat,	Approximate
3760, rted within 24 hours completely filled in b	00 Pe		iMMEDIATE CAUSE (Final disease Dr condition resulting in death)	EPSIS						Interval Batween Onset and Death
cxecuted within	<b>च</b> 6	NO	Securetially the condition of b.	NEMON	IA					
	traun	CATI	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	OUE TO (OR AS A CONS	EQUENCE OF):					
OS, P.O. BO) he death certificate be the attending physician	or off	CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A CONS	EOUENCE OF):					
- 41 6	d Mental	- 1	PART II. Other aignificant conditions contribut	Ing to death but not	resulting in the	underlying cause also	n in Bart I	04- 1400 011 01770	anay Lan	
RECORD requires that the	any I	EDICAL	TERMINAL	Colon		BUCEB		24a. WAS AN AUTO PERFORMED	?	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?
L RE( law requir	Dept. of Heal	≥								1 - YES 2 - NO
The The	000	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		ОТН	26, PLACE OF DEAT	H (Check only one	)		
OF VIT,	the S	PHYS		nt 2 ER/Outpatient		Nursing Home 5 Reside		(Specify)	N OCCUPED	
3	marked	BY PI	1 Netural 5 Pending 2 Accident Investigation	lonth, Day, Year)	INJURY	WORK?		CHIBE HOW INJUR	Y OCCURED	
N	ns after d m 28 ts	ETED	4 Homicide detarmined	LACE OF INJURY — At I lilding, atc. (Specify)	home, farm, street,	factory, offica	28I. LOCA City o	NTION (Street and Ni or Town, State)	lumber or Rural Ro	ute Number,
D COSPITAL OF	WT. If Item	COMPLET	29a. CERTIFIER (Check only one)  2 MEDICAL EXAMINER: On the ba	best of my knowledge, o	death occurred at the investigation, in $\pi$	ne time, date end place, end ny opinion, death occured a	d due to the cause	ee(a) and manner a and place, and due	e to the cause(a)	and manner as stated.
日子	be fied within 72 h IMPORTANT: If I	TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER SEARCH	ansa 1	APP 1920A	29c. LICENS!	D 427		DATE SIGNED	Month, Pay, Year)
			11.	CAUSE OF DEATH (IT	EM 27) (Type, Print)	of FORD mg	59 a sm	736.	A 9.	
			31. DATE FILED (Month, Day, Year) APR 06 1993  Julia Da	SISTRAR'S SIGNATURE	M.					

BALTIMORE, MARYLAND 21215-0020	4 hours after death. Page 6 may be retained by the hospital or attending physician.	filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. In, or removal.	e medicai examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR THE DAME THIS CLAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR AND STATE DEPT. OF Health and Mental Miglene prior to burlal, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

Pages 1, 2, 3 should

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	1 - FOR STATE REGISTRAR	STATE OF MA					EALTH A			GIEN	E	3 (	19020
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DE	ATH			3. TIME OF DEATH
	Rudolph			Si	mmoi	ns S	Sr		03	DA	993	8:27 P.M	
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. la	st birthday)	IF UNDER		IF UNDER 24	-	7. DATE OF BIF (Month, Day,	Mari			HPLACE (State or Foreign
	217-16-5009	1 M 2 F	69	YRS.	MONTHS	DAYS	HOURS	MIN.	10-29	9-2	3	Courk	mD .
~	9e. FACILITY NAME (If not institution, give str	reet end number)			9b. CITY	, TOWN	R LOCATION	OF DEAT	тн		9c. COL	INTY OF D	DEATH
DIRECTOR	Union Memorial	Hospit	al		Ba.	<u>ltin</u>	nore	Cit	У				
R	10e. STATE 10b. COUNTY				Y, TOWN								10d. INSIDE CITY LIMITS?
	MD			Ba	alti	mor	e						1 💢 YES 2 🗌 NO
3AL	10e. STREET AND NUMBER						. ZIP CODE				10g. CIT	IZEN OF	WHAT COUNTRY?
FUNERAL	2436 Barclay			_			21218	_				JSA	
F	11. MARITAL STATUS  1 Never Merried 2 Merried	12. WAS DECEDENT I FORCES? 1 (X	YES 2 [	MED NO	13.	WAS DEC	ENDENT OF	HISPANIC Mexican.	ORIGIN? (Spe	cify Yes	or No	14. RACI Black	E — American Indian, k, White, etc.
BY	IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: Specify:											My: D 1 2 0 k	
O	15. DECEDENT'S EDUC		18s, DE	CEDENT'S	USUAL O	CCUPATIO	DN .		16b. KIND	OF BUILD	IMECC/IM	DIJETOV	Black
ETI	(Specify only highest grade ( Elementary/Secondary (0-12)	College (1-4 or 5 +)	(G		work done		st of working						y Care
릴									Cent				y ourc
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTHE	R'S NAME	(First, Middle,	_	Sumame)		
BE							Eliz	abe	th Wi	11	iams	3	
10	19e. INFORMANT'S NAME (Type/Print)		19	b. MAILINO	ADORES	S (Street e			rte Number, City				
F	Rudolph Simmons		200	2813	Ri	dge	boow	Ave	./Bal	tir	nore	, M	D 21215
	25s. METHOD OF BISPOSITION 1) Burlal 2 Cremittion 3   Hemp	wai from State	20b. PLACE	AND DATE	OF DISPOS	ITION (Na	me of		OATE 2	20c. LOC	ATION -	City or To	wn, State
	4 Donation   S D Other (Specify)	- 4	K ing	Men			Park			and	dall	sto	wn, MD
	21. SIGNATURE OF FUNERAL SERVICE LICE	Land Land	nn II.		22.	NAME AN	D ADORESS	OF FACIL	ITY YTI				
	- IVONULIA	87111	1110		W	M C	. MAR	RCH	F.H./	110	01 E	. N	ORTH AVE.
	23. PART 4 Eriter the diseases, or cr shock, or heart failure. L	int only one cause	on each line	ath. Do r	not antar	tha mo	da of dying	, such a	s cardiac o	respir	atory ar	rest,	Approximate
	IMMEDIATE CAUSE (Final					1							Intarval Between Onset and Death
	disease or condition resulting in death)	Arlens	esclere	olic	Car	dio	vasc	ula	u dis	ua	L		
			R AS A CONSE										
S	Sequantially list conditions,	DUE TO (O	R AS A CONSE	NIENOE O				_					
AT	if any, leading to immediate cause. Enter UNDERLYING	DOE 10 (OI	AS A COMSE	DUENCE OF	r):								
띮	CAUSE (Disease or Injury that Initiated events	OUE TO (OI	R AS A CONSE	DUENCE OF	 F):								
CERTIFICATION	resulting in death) LAST												
- 11	DATE II ON THE I												
PHYSICIAN: MEDICAL	PART II. Other significant conditions	contributing to da	ath but not r	asulting i	n tha un	dariying	cause giv	en in Pa		MAS AN A	WTOPSY WED?	24b.	. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
ă	Chronic olistr	ullive pe	umone	24	als	las	<i>K</i>		- 1X	YES 2	□ NO		OF DEATH?
ž									-				1 XYES 2 NO
¥	25. WAS CASE REFERRED TO MEDICAL												
泛	EXAMINER?	HOSPITAL: Y			OTHER	<b>1</b> :	ACE OF DEAT						
¥∥	27. MANNER OF DEATH	28e. DATE OF IN.		28b. TIM		28c. INJ		_	Other (Special Control of the Contro		### 00	CHECO	
ᅙᆘ	4 Number   10 miles	(Month, Day,		INJ	URY	WO	RK?		od. DESCRIBE	now in	JUNY OC	COMED	
	1 Natural 5 Pending							_	N LOCATION	/C4		or Purni E	
₽	2 Accident Investigation	28e. PLACE OF II	NJURY — At ho	me, term, s	troot, fact	ory, office	)	1 21					Printe Number
B		28e. PLACE OF II building, etc	NJURY — At he . (Specify)	me, term, s	street, fact	ory, office		20	City or Town	State)	na Numbe	Or Horar	Route Number,
B	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	building, etc	. (Specify)						City or Town	, State)			loute Number,
₽	2 Accident 3 Suicide 8 Could not be determined  29e. CERTIFIER (Check only 1 CERTIFVING PHYSIC	IAN: To the best of my	knowledge, de	sth occurre	ed at the ti	me, date	and place, er	nd due to	City or Town	, State)	ner as sta	led.	
COMPLETED BY	2 Accident 3 Suicide 4 Homicide 8 Could not be determined  29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC MEDICAL EXAMINER	IAN: To the best of my	knowledge, de	sth occurre	ed at the ti	me, date	and place, er	nd due to	City or Town the cause(e) e	, State)	ner as star	led. Te cause(s	) end manner as stated.
BE COMPLETED BY	2 Accident 3 Suicide 8 Could not be determined  29e. CERTIFIER (Check only 1 CERTIFVING PHYSIC	IAN: To the best of my	knowledge, de	sth occurre	ed at the ti	me, date	and place, er path occured	at the tim	City or Town the cause(e) e ne, date and pl	, State)	due to the	ted. ne cause(s E SIGNEO	) end manner as stated. (Month, Day, Year)
COMPLETED BY	2 Accident 3 Suicide 4 Homicide  29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER  29b. SIGNATURE AND TITLE OF CERTIFIER  ACCIDENT OF THE OF CERTIFIER  ACCIDENT OF THE OF CERTIFIER  ACCIDENT OF THE OF CERTIFIER  ACCIDENT OF THE OF CERTIFIER  ACCIDENT OF THE OF CERTIFIER  ACCIDENT OF THE OF CERTIFIER  ACCIDENT OF THE OF CERTIFIER  ACCIDENT OF THE OF CERTIFIER  ACCIDENT OF THE OF CERTIFIER  ACCIDENT OF THE OF TH	IAN: To the best of my: On the best of exem	knowledge, de	sth occurre	nd at the ti	me, date	and place, er path occured	nd due to	City or Town the cause(e) e ne, date and pl	, State)	due to the	ted. ne cause(s E SIGNEO	) end manner as stated.
BE COMPLETED BY	2 Accident 3 Suicide 4 Hornicide 8 Could not be determined  29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER  30. NAME AND ADDRESS OF PERSON WHO	IAN: To the best of my: On the best of exem	knowledge, de kn	nveatigatio	n, in my o	me, date	and place, er beth occured 29c. LICENS	at the time	City or Town the cause(e) e ne, date and pl	nd manr	due to ti	ted. ne cause(s E SIGNEO	) end manner se stated. (Month, Day, Year)



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THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 35 yours after	May this corriecte has been sinned by the attendion physician and completely filled in by
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Pages		
permit.		
TITH After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.		
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funeral		to marked or item 23 shows not injury or other traumatic event, the medical examiner must be notified at one
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R. An	an de	S de
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FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR	CE	RTIFIC	ATE OF	DEATH	RE	EG. NO.	-				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF D	EATH DA		YEAR	3. TIME OF DEATH		
	Florence L So	anders				04	0		93	306 R M		
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (in yrs. last	birthday) I	F UNDER 1 YEAR	7. DATE OF BIRTH 8. BIRT				PLACE (State or Foreign			
	215-07-8187 10 M2 1	18	YRS.	ONTHS DAYS	HOURS MIN.	(Month, Day, Year)			Country	n Q		
	9a. FACILITY NAME (If not institution, give street and number	4	OF DEATH									
TOR	Greater Baltimore Medic	al Center		^ To	wson			(	Sat	۲.		
E C	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ION				$\neg$	10d. INSIDE CITY		
8	Maryland Baltimor	e		Cockey	sville					LIMITS? 1 YES 2 Y NO		
FUNERAL DIRECTOR	100. STREET AND NUMBER 200 Enternational				ZIP CODE 210	30		10g. CITIZEN OF WHAT COUNTRY?				
빌	11, MARITAL STATUS 12. WAS DEC	COENT CHED IN I.C. ADI	4ED	10 MM 0 DEC			- ald . Va a	as No.		— American Indien.		
B≺	1 Naver Married 2 Married FORCES	EDENT EVER IN U.S. ARI ? 1 TYES 2 N BIVE WAR OR DATES		If yes, spe	ENDENT OF HISPAN city Cuban, Mexica 2 NO Specify	n, Puerto Rican		or No —	Black Specif	, White, etc.		
G	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working											
	Elementary/Secondary (0-12) Cotlege (1-4 or 5 +)											
7	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,									_		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	•			18. MOTHER'S NA	ME (First, Middle	, Maiden	Sumame)				
0	Charles Franklin Smit	h			Mary F	lorenc	e Br	ooke				
BE	19e. INFORMANT'S NAME (Type/Print)		MAILING A	DDRESS (Street &	nd Number or Rural F	Route Number, C	ity or Town	n, State, Zio	Code)			
2	Maryland Masonic Home				onal Cir					21030		
	20a. METHOD OF DISPOSITION				netery, crematory or			CATION —				
	1 X Burial 2 Cremation 3 Removal from Sta	te other pla	ca)									
	22. NAME AND ADDRESS OF FACILITY 6500 York Rd. Bal											
	Goorge Veyrarse	9		Mitch	ell-Wied	lefeld	Home	9		21212		
CERTIFICATION	Sequentielly list conditions, if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	UE TO (OR AS A CONSECUE TO (OR	DUENCE OF):		T (	ance				interval Between Onset and Death		
與	d											
PHYSICIAN: MEDICAL O	PART II. Other significent conditions contribution	101		A res			PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE			
A	25. WAS CASE REFERRED TO MEDICAL			28. PI	ACE OF OEATH (Ch	eck only one)						
SIC	EXAMINER?  1 YES 2 NO 1 Inputier	L: nt 2 ER/Outpetient 3		OTHER:	e 5 🗆 Residence	8 Other (So	ecify)					
ΗX	27. MANNER OF GEATH 28a. DA	TE OF INJURY	28b. TIME	OF 28c. INJ	URY AT	28d. OE\$CRI		NJURY OC	CURED			
	1 Natural 5 Pending	onth, Day, Year)	INJUI		RK7 YES 2 NO							
ВУ	2 Accident Investigation 3 Suicide 8 Could not be 28e. PL	ACE OF INJURY — At ho	me, farm, str			28f. LOCATIO	N (Street I	and Number	or Rural F	Route Number,		
ED		illding, etc. (Specify)					wn, State)			,		
COMPLET	29a. CERTIFIER		_			L						
AP.	(Check only					-						
Ö	2 MEDICAL EXAMINER: On the bar	ila of examination andior	investigation,	in my opinion, d	eath occured at the	time, data and	place, an	id due to th	ie cause(s	a) and manner as stated.		
BE	29b. SIGNATURE AND TITLE OF CONTIFIER	bam		m	29c LICENSE NUI	MBER 48	8	29d. DAT	SHENED	2 Month, 27 Year)		
5	30. NAME AND ADDRESS OF PERSON WHO COMPLETE	D CAUSE OF DEATH (ITE	M 27) (Type, F	rint)		1			-			
	31. DATE FILED (Month, Day, Year) 32. REG	GISTRAR'S SIGNATURE	700	= = = = = = = = = = = = = = = = = = =				· ·				
	ADD 06 1993 dulia	Davidson-Rand	200									

BALTIMORE, MARYLAND 21215-00

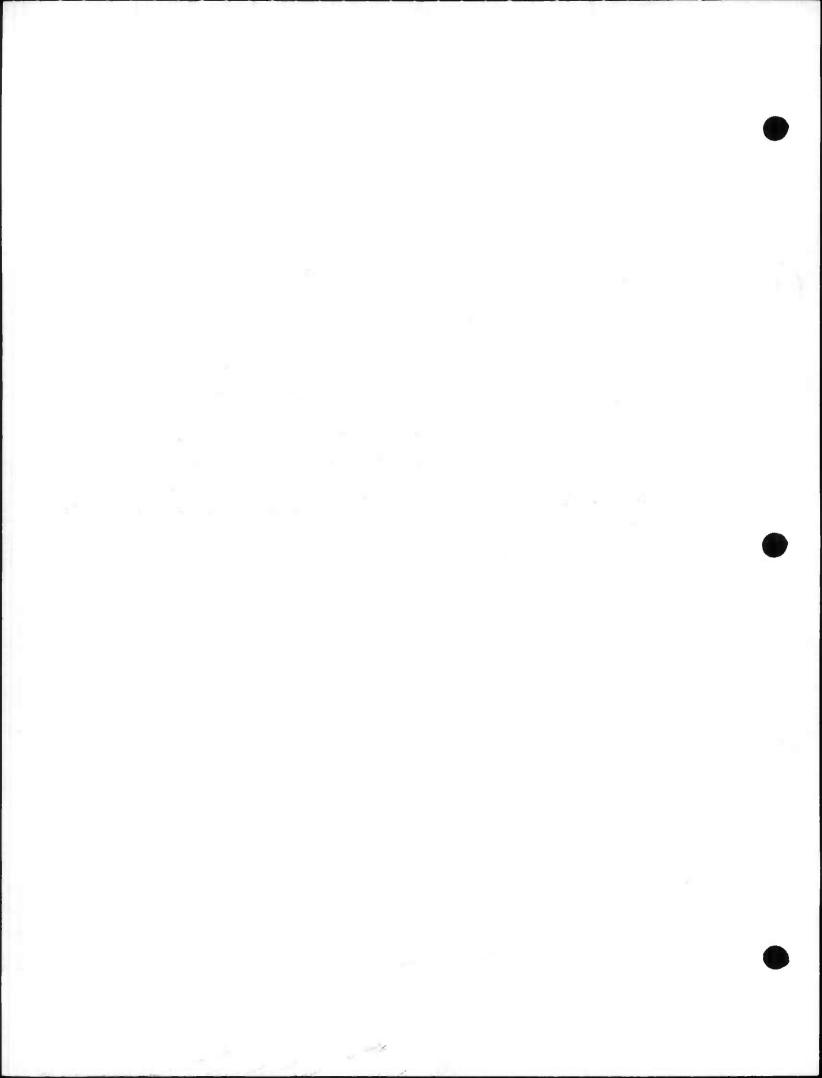
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	ICATE OF	DEATH	REG. I	10.				
	1. DECEDENT'S NAME (First Middle, Last)	A	SAL	KS		2. DATE OF DEATH	DAY 1	3. TIME OF DEATH			
	0.01 0.00	1 M 2 D + 78	In yrs. lest birthdey) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year, 10/18/1	0.	BIRTHPLACE (State or Foreign Country) MARYIJAND			
TOR	98. FACILITY NAME (If not institution, give str 2904 MARNAT RD.,			BALTIMO	OR LOCATION OF DE	АТН	9c. COUNTY BALTI	Y OF DEATH MORE			
ည	10a. STATE 10b. COUNTY		100 000	Y, TOWN OR LOCA	FIGN						
L DIRECTOR	MARYLAND BALTI	MORE		TIMORE				10d. INSIDE CITY LIMITS? 1 YES 2 X NO			
FUNERAL	2904 MARNAT RD.,				21209		USA	N OF WHAT COUNTRY?			
B₹	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 _ YES IF YES, GIVE WAR OR DO	2 NO	if yes, sp		IIC ORIGIN7 (Specify n, Puerto Rican, etc.) /:		I. RACE — American Indian, Black, White, atc. Specify: WHITE			
	15. DECEDENT'S EDUC. (Specify only highest grade of	ATION	16a. DECEDENT'S	USUAL OCCUPATION	ON	16b. KIND OF	BUSINESS/INDUS	TRY			
COMPLETED	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5 +)  INTERIOR DECORATOR  DESIGN										
BE CON	ISRAEL SIGED GIDDI DACID										
10	190. INFORMANT'S NAME (Type/Print) DAVID SACKS					Oute Number, City or B BALT					
	20a. METHOD OF DISPOSITION A Burlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. PLACE AND DATE Of DISPOSITION (Name of cametery, cremetory or other piece) HEBREW YOUNG MEN 4/5/93  DATE 20c. LOCATION - City or Town, State BALTIMORE, Md										
	21. SIGNATURE OF FUNERAL SERVICE CENSEE  22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC.										
_	D T V	Berra		1 6010	REISTERT	OWN RD.	BALTO.,	MD 21215			
	23. PART I. Enter the diseases, or concendence or condition resulting in death)	DUE TO (OR AS A	ach iine.				apiratory arrea	Approximate Interval Between Onset and Death			
NOI	Sequentially list conditions,	Prevmoni						U			
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	7):							
CERT	resulting in death) LAST										
DICAL	PART II. Other algnificant conditions	contributing to death b	ut not reaulting i	n the underlyln	g cause given in	PERI	AN AUTOPSY FORMED?	24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE			
뿔							n donly	OF DEATH?			
Z							nees				
ਹ	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:	LACE OF DEATH (Ch	eck only one)					
S	1 VES 2 NO	1 Inpatient 2 ER/Outp	atlent 3 DOA		ne 54 Residence	6 Other (Specify)					
BY PHYSICIAN:	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	26a. DATE OF INJURY (Month, Day, Year)	26b. TIM	URY WO	URY AT DRK? YES 2 NO	28d, DESCRIBE HO	W INJURY OCCU	RED			
	3 Suicide 6 Could not be 4 Homicide detarmined	28e. PLACE OF INJURY building, atc. (Spec	— At home, farm, a	street, factory, offic		261, LOCATION (Stree City or Town, St		Rural Route Number,			
COMPLETED		CAN: To the best of my know						cause(a) and manner as stated.			
BE C	296. SIGNATURE AND TITLE OF CERTIFIER	El mo			29c. LICENSE NUN		29d. DATE S	HGNED (Month, Day, Year)			
5	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type,	Print)	1357 412		4/	2/93			
	STEPHEN G. K 31. DATE FILED (MONTH, Day, Year)	EICH MI), N 32. REGISTRAR'S SIGN	ATURE ATURE	Johns 1h	201978 10	spital	Back	21287			
	APR - 6 1993	Julia Varidona	Bodek.					DHMH.16 Rev. 1/89			

BALTIMORE, MARYLAND 21215-1026	4 hours after death. Page 6 may be retained by the hospital or attending the second se	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlar-fransit permit. Pages 1, 2, 3 should	n, or removal.	made to hell the addition and second testing
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fi	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.	IMPORTANT: If Hem 28 is marked or Hem 23 shows any injury or other traumatic event the medical avantage must be available at some

	FOR 1 - STATE REGISTRAR		STATE OF I					IEALTH AND DEATH	MEN	TAL HYGIEN		3	096	31
	1. DECEDENT'S NAME (First, A	Aiddle, Last)		L EO	NARD		sc	HLOSS		ATE OF DEATH	<b>J</b> '2	<b>1543</b>	3. TIME OF E	P.
	4. SOCIAL SECURITY NUMBE	R	5. SEX	6. AGE (In yrs	s. last birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.		TE OF BIRTH lonth, Day, Year)		8. BIRTH Countr	PLACE (State of	
	9e. FACILITY NAME (If not inst	itution, give st	**	, 1		9b. CITY,	TOWN	OR LOCATION OF D	EATH	1/9/1918	<del>-</del>	MAR INTY OF D	YLAND.	
OR	2800 TANE		ΔD			BAL	TIM	ORE CI	ΤY		110000			
DIRECTOR	RESIDENCE OF DECE	DENT 10b. COUNTY			10c, Cl	TY, TOWN O	R LOCAT	TION					10d, INSIDE	NTV
RIO	MARYLAND					TIMO							LIMITS?	
AL	10e. STREET AND NUMBER						101	I. ZIP CODE		-	10g. CIT	IZEN OF W	WHAT COUNTR	
FUNERAL	2800 TANEY R	D.						21209			USA			
	11. MARITAL STATUS  1 Never Married 2 M	erried	12. WAS DECEDEN FORCES? 1	YES 2	NO	1	f yes, sp	ENDENT OF HISPA ecify Cuben, Mexic	en, Puer		e or No-	Black	- American , White, atc.	Indian,
BY	3 Widowed 4 Divorc	ed	IF YES, GIVE W	WII		'	YES	X NO Speci	lfy:			Speci WHI	•	
	15. DECEI (Specify only I	DENT'S EDUC highest grade	CATION completed)	16a	. DECEDENT'S	work done o				16b. KIND OF BU	SINESS/IN			
PLE	Elementary/Secondary (0-1	2)	College (1-4 or 5		in. Do NOT L				l <sub>1</sub>	LUMBER (	~O.			
COMPLETED	17. FATHER'S NAME (First, Mide	die, Last)			71.0001.1			18. MOTHER'S NA	- 1					
BE C	BENJAMIN	SCHLC	SS_					ETHE	LI	NATHAN				
2	19e. INFORMANT'S NAME (Typ				19b, MAILING	G ADDRESS	(Street e	and Number or Rural	Route N	lumber, City or Tow	n, State, Zi	p Code)	_	
	VIVIAN ZIPPEF	N.		000 000		MEHE			AT TY		21208			
	X □ Buriel 2 □ Cremation 4 □ Donation 5 □ Other (S	3 🗆 Remo	oval from State	cemetecy BN	AT ISI	RAEL		1/93				City or To		
	21. SIGNATURE OF FUNERAL		ENSEE					D ADDRESS OF FA	ACILITY	IBAL!	TTMOF	RE, M	D	
	foel	- U	De	is				EVINSON REISTERT					01.01	_
	23. PART h Enter the dis-	eeses, or c	omplications the	t coused the	deeth. Do	not enter	the mo	de of dying, suc	ch as c	erdiec or resp	iratory ar	reat,	Approx	rimate
	IMMEDIATE CAUSE (Fina disease or condition resulting in death)	i	Arteri		rotic		dic	ovascul	ar	Disea	se			i Between and Death
CERTIFICATION	Sequentially list condition if any, leading to immedicause. Enter UNDERLYIN CAUSE (Disease or injury that initiated events resulting in death) LAST	ate G		(OR AS A CON										
H	resolding in deadily CAST													
PHYSICIAN: MEDICAL	PART II. Other algorificent	condition	contributing to	deeth but n	Dt reculting	in the unc	derfying	g ceuse given in	Part i.	PERFOR	RMED?		WERE AUTOPS AMAILABLE PR COMPLETION OF DEATH? 1 YES 2	OF CAUSE
AN	25. WAS CASE REFERRED TO	MEDICAL					28. PL	ACE OF DEATH (C)	hack only					
SIC	EXAMINER?	Ì	HOSPITAL:	ER/Outpation	R 3 🗆 DOA	OTHER		e 5 Nesidence						
ву рну	27. MANNER OF DEATH  1) Natural 5 Pe 2 Accident Im	nding	28a. DATE OF (Month, D		28b. TIA		28c. INJ	URY AT	_	DESCRIBE HOW I	NJURY OC	CURED		
	3 Suicide 6 Co	ould not be termined	28e. PLACE O building,	F INJURY — A atc. (Specify)	t home, farm,	street, tacto	ory, offic	•	28f. L	OCATION (Street ( City or Town, State)	and Numbe	r or Rural R	oute Number,	
COMPLETED			CIAN: To the best of										and manner	na atata-i
2	298, SIGNATURE AND TITLE O		and the same of th	1				29c. LICENSE NU					(Month, Day, Ye	
2	30. NAME AND ADDRESS OF F	ERSON WHO	COMPLETED/CALIF	SE OF DEATH	TEM 271 / Town	Print		O.C.M		•		-3-		7
	11	OLLE	JR. M.	D.	111 E		St	reet, E	Bal <sup>.</sup>	timore	, Ma	ryl	and	21201
	APR - 6 10	,	Julia Sain	1000										
	AFR - U	127	O THE WALL	The state of the s	CT-TE				_				District	H-16 Rev 1/89



DHMH-16 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 24 hours after death. Page 6 may be retained by the hospital or attending physician. notified at pe must examiner the funeral medicai the attending physician and completely filled in by Mental Hyglene prior to burial, cremation, or remo the HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within event, traumatic other 0 signed by the Health and has been signed by the Dept. of Health and m 23 shows any in ir this certificate has th with the State De narked, or Item 2 FUNERAL DIRECTOR; After within 72 hours after death 60 IMPORTANT: If Item 28 표보 223

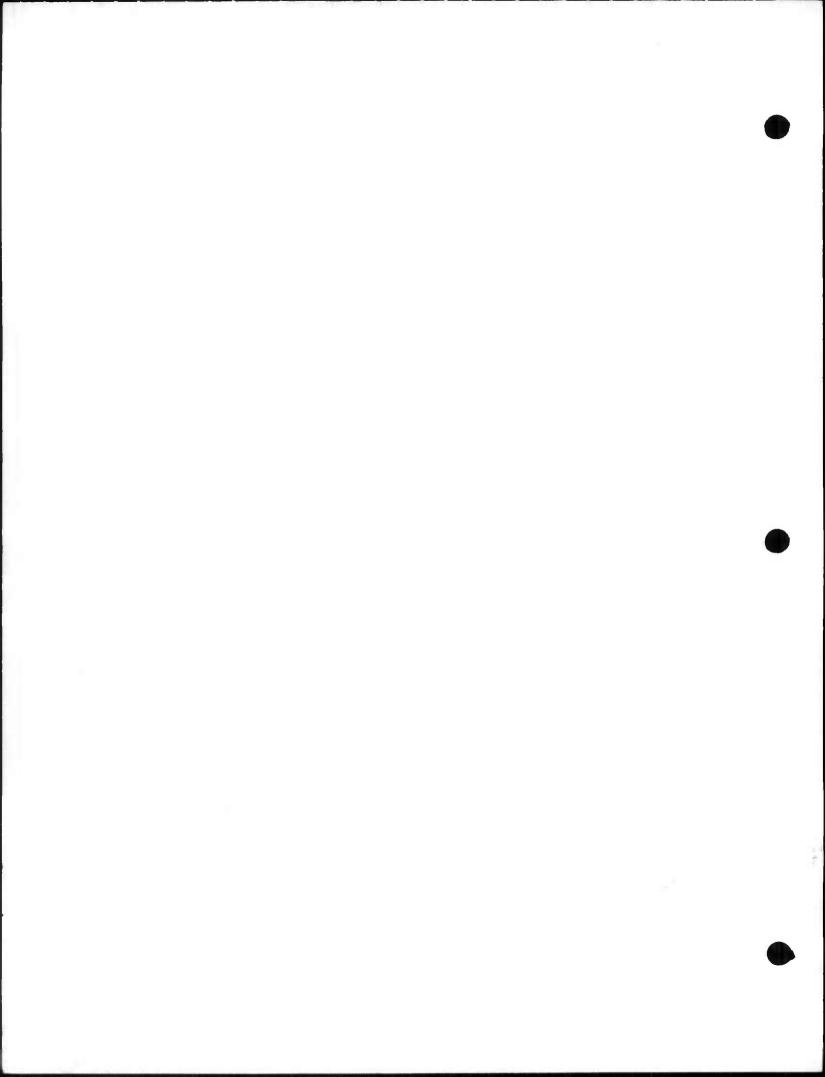
1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR 04-03-93 Stefanelli Joseph Anthony 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH 1. (Month, Dev. Year) 1. 2 - 0.8 - 0.6 IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign DAYS HOURS Italy 1 🔀 M 2 🗌 F 86 YRS. 578-01-0701 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Anne Arundel Sevarden Lane Crownsville RESIDENCE OF DECEDENT 10b. COUNTY Crownsville 10d. INSIDE CITY LIMITS? MD Anne Arundel 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 967 Sevarden Lane 21032 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 15 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2x XMarried If yes, specify Cuban, Maxican, Puerto Ri 1 TES 2 NO BY Specify: Specify: White 3 Widowed 4 Divorced WWII ETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Tile Business 8 Owner/operator 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname) Rosella Della Vecchia <u>Gaetano Stefanelli</u> BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 967 Sevarden Lane, Crownsville, MD 21032 Carmel Stefanelli 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE 208. METHOD OF DISPOSITION

(C) Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) Our Lady of the Fields Millersville, MD 21, SIGNATURE OF PUBLISH SERVICE LICEN 22. NAME AND ADDRESS Hardesty Funeral Home, P.A. as 12 Ridgely Ave. Annapolis, MD 21401 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. interval Between Onset and Death IMMEDIATE CAUSE (Finsi disease or condition Omege OUE TO (OR AS A CONSEQUENCE OF) resuiting in death) MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 | YES 2 | NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA ne 5 - Residence 8 - Other (Specify) 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28h. TIME OF 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED INJURY 1 Netural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28e, PLACE OF INJURY -- At home, farm, street, factory, office 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be determined 4 Homicide 29a. CERTIFIER

(Chank aniv 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner ee stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. SI WATER AND TIPLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 4-5-57 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

what Davidson- Bondelle



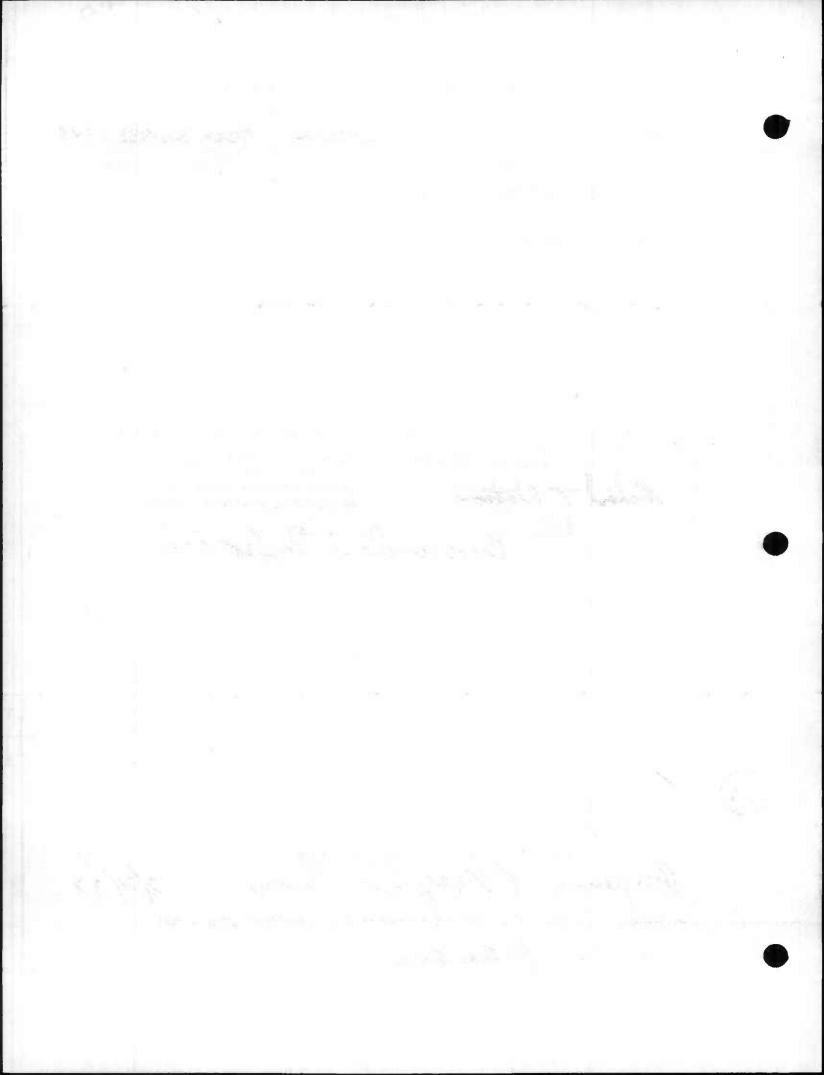
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1 - FOR STATE REGISTRAR

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	3	1. DECEDENT'S NAME (First	I, Middle, Last)				-				2. DATE OF	DEATH	w	VEAC	3. TIME OF OEATH
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P 19		4. SOCIAL SECURITY NUMBER	BER	5. SEX	8. AGE (In	yrs. last birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF (Month, D	BIRTH	1	8. BIRTH Countr	IPLACE (State or Foreign
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Pages	REC	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION												10d. INSIDE CITY	
permit. P	1	Maryland		ester		Bis	hopvi	_							1 TES 2 NO
	ERAL	100. STREET AND NUMBER						100	. ZIP COD				Contract		VHAT COUNTRY?
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020 physician. burial-trar	FUNE	1 Never Married 2		FORCES? 1	YES	2 NO	3	If yes, sp	ecify Cubs	ırı, Mexica	IIC ORIGIN? (S n, Puerto Rica		or No-	Black	— American Indian, c, White, etc.
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⊈ ° N	J.	Elementary/Secondary (	0-12)	College (1-4 or 5	+)	(Give kind of work done during most of working life. Do NOT use retired.)						_			
AND 2 he hospital detached to	COMPL	8 17. FATHER'S NAME (First, A	Airiclin I not)			maid			40				otel	indu	stry
1 2 2 K	_	Herbert Tir									ME (First, Midd	me, Meiden	Sumame)		
E 2 2 2	BE	19a. INFORMANT'S NAME (				19b. MAILING	ADDRESS	S (Street		na La	AWS Route Number,	City or True	n. State 7in	Code1	
5 5 W E	임	Alton G. Mod											21813		
RE, may be or, page	-V	29a. METHOD OF DISPOSIT	TION	and from Cart.	20b. P	12850 Old Stage Road, Bis							CATION — C		
0 0 0 E		4 Donation 5 D Other	r (Specify)		Eve	ery. crematory or o	Ceme	ter	У		4/3	Ber]	rlin, Md.		
		21. SIGNATURE OF FUNERAL MERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  Watson Funeral Home, Inc.													
		Nechair	17	Wats	on						ral Ho Delawa	-			
\$ > E 3		23. PART I. Enter the d	liseases, or o	complications the	t caused t	the death. Do	not enter	the mo	de of dy	ing, suci	h aa cardiad	or respi	ratory arre	eat,	Approximate
y filled in the fillen, or rer		IMMEDIATE CAUSE (FI		t/	100 011 020	ar ining.	05	0	C	2	0 -	1	0		Onset and Deat
thin 2 etely 1 ematio		disease or condition resulting in death)	$\rightarrow$	. W	40	carr	Xe.	al	Y	ny	arc	10	27		
executed within and completely o burial, cremar matte event,				DUE TO	IOR AS A C	ONSEQUENCE O	F):			V					
OX 687  e be executed sician and cornior to burial, traumatic e	ON	Sequentially list conditions, If any, leading to immediate													
traus	CAT	r arry, leading to immediate cause. Enter UNDERLYING													
O. B. ertificate ng phys giene pr	FI	CAUSE (Disease or Injuthat Initiated events	CONSEQUENCE O	EQUENCE OF):											
endi P	CERTIFICATION	resulting in death) LAST													
ORDS, that the dea by the att th and Menta any Injury,	- 1	PART II. Other significa	ant condition	s contributing to	death but	not resulting	In the ur	deriyin	g cause (	given in	Part I. 24	e. WAS AN		24b.	WERE AUTOPSY FINDINGS
ORDS that the sed by the lift and Me any Inju	AEDICAL										1	PERFOR			AMAILABLE PRIOR TO COMPLETION OF CAUSE
Sign Heal	MEC										_   '				OF DEATH?
3 5 S S	z														lad see
E ste the	HYSICIAN:	25. WAS CASE REFERRED T EXAMINER?	O MEDICAL	HOSPITAL:			OTHER		ACE OF D	EATH (Chi	ock only one)				
VIAN:	IXSI	1 TYES 2 NO		1 - Inpatient 2			4 🗆 Nur	sing Horr		esidence	8 Other (S				
S E E	0	27. MANNER OF DEATH	Pending	28a. DATE OF (Month, D		28b. TIM	URY M	_	PRIC?	_ NO	28d. DEŞCR	IBE HOW IN	JURY OCC	UREO	
S(MA)	BY	2 Accident	Investigation	28e. PLACE O	F INJURY -	- At home, farm,	street, fact		YES 2	_ NO	28f. LOCATIO	ON (Street -	nd Number	or Revel 5	Proude Alcombar
0	ETED	4 Homicide	Could not be determined	building,	etc. (Specify	)		, 01110	-			own, State)	ria reuttioni (	un muran P	
OR ATT DIRECT Hours	J.	29a. CERTIFIER 1 CERT	TIFYING PHYS	CIAN: To the best of	my knowles	ice, death new-	ad at the s	lma dua-	and also	and de-	to the ease of	a) and ==			
로 정신 =	COMPL														) and manner se stated.
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: If		296. SIGNATURE AND TITLE			/					ENSE NUN		T			(Migram, Day, Ybar)
THE OTHE DE filed IMPOR	H C	(keingo	uis	# 1	Nes	ele.			Da	1074	3		<b>&gt;</b> 5	/3/	793
	2	30. NAME AND ADDRESS O	F PERSON WH		SE OF DEAT	H (IZEM 27) (Type	, Print)						4	1	
of		Benjamin 4	. Meyer		Buine	14+100	ust	5+5	- Sa	lisbu	un, M	0.21	801		
4		31. DATE FILED (Month, Day.		32. REGISTRA		URE					7.				
		APR 06	1993	Julia De	Helman	Books									

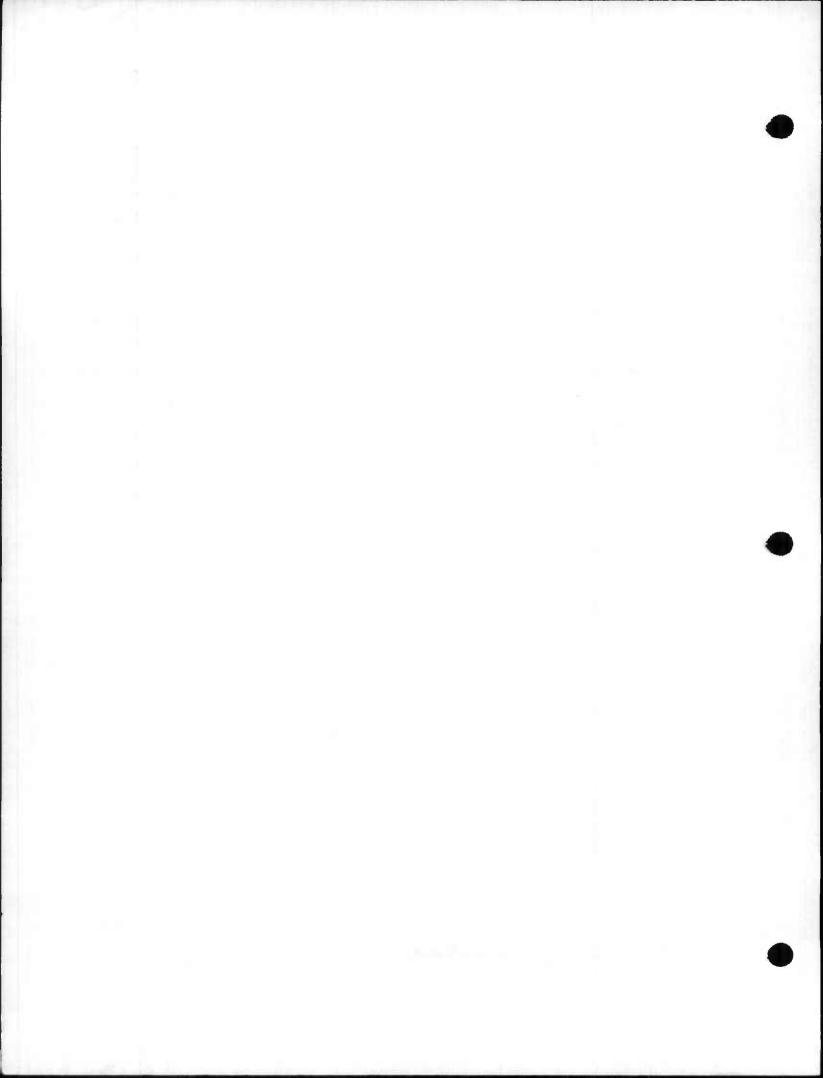
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



BALTIMORE, MARYLAND 21203-3146

STATE OF MARYLAND	/ DEPARTMENT	OF I	HEALTH .	AND	MENTAL	HYGIENE
	ERTIFICATE	OF	DEAT	H		REG. NO.

1	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM			MENTAL	HYGIENE REG. NO.	9	3 09634
1	1. DECEDENT'S NAME (First, Middle, Last)	241				2. DATE O	F DEATH DAY		3. TIME OF DEATH
	Genevieve Sn 4. social security number			UNDER 1 YEAR NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE DI (Month, MAY	4 F BIRTH 28,1916	0.0	3 8:50 am M SHITHPLACE (State or Foreign Country) Maryland
	9a. FACILITY NAME (# not institution, give a Riverview Nurse RESIDENCE OF DECEMENT				SSEX	ATH	9	Balt	of DEATH Cimore
	Md. Ba	altimore	10c. CITY, T	OWN DR LOCAT					10d. INSIDE CITY LIMITS? 1 YES 2 H ND
Ç H	100. STREET AND NUMBER 800 Mace Ave			101.	ZIP CODE 212	21	10	og. CITIZEN	USA
10	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FDRCES? 1 YES IF YES, GIVE WAR DR	2 ND	If yes, spe	ENDENT OF HISPAN city Cuban, Mexicar 2 NO Specify.	, Puerto Ric	(Specify Yes or can, etc.)		RACE — American Indian, Black, White, etc. Specify: White
	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	16a. DECEDENT'S US (Give kind of work life. Do NOT use n	done durina moi	N II of working	16b. I	(IND OF BUSIN	ESS/INDUST	
5	17. FATHER'S NAME (First, Middle, Last)	Sieracki			18. MOTHER'S NAM		ddle, Maiden Sur Marie	name)	,
20	19a. INFORMANT'S NAME (Typo/Print) Sharon Tusing	J			nd Number or Rural R	loute Numbe	c, City or Town, S		21221
	20s. METHOD OF DISPOSITION  PD Buriel 2 Cremation 3 Ren 4 Donation 5 Other (Specify)	noval from State	other place of DISPOSITION OF PLACE OF PLACE OF DISPOSITION OF PLACE OF DISPOSITION OF PLACE OF DISPOSITION OF PLACE OF DISPOSITION OF PLACE OF DISPOSITION OF PLACE OF DISPOSITION OF PLACE OF DISPOSITION OF PLACE OF DISPOSITION OF PLACE OF DISPOSITION OF PLACE OF DISPOSITION OF PLACE OF DISPOSITION OF PLACE OF DISPOSITION OF PLACE OF DISPOSITION OF PLACE OF PLACE OF PLACE OF PLACE OF DISPOSITION OF PLACE OF PLA			or Town, State e Md.			
	21. SIGNATURE OF FUNERAL SERVICE LI	Funda	Home		lyFunera		e 300Ma	ceAve	21221
	23. PART I. Enter the diseases, or shock, or heart faikire.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	a. Due TO (DR AS	A CONSEQUENCE OF):  A CONSEQUENCE OF):  A CONSEQUENCE OF):	LYOCA	ADIAL	INI	FARCT	1124	Interval Between Onset and Death
MEDIANE	PART II. Other significant condition	ns contributing to death  EDEME		the underlying	g cause given in		24e. WAS AN AU PERFORME 1 NES 2	D?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO	HOSPITAL:			ACE OF DEATH (Che				
	27. MANNER OF DEATH  1 Natural 5 Pending	26s. DATE OF INJURY (Month, Day, Year)	28b. TIME (	OF 28c. INJ	URY AT RK?		(Specify) CRIBE HOW INJ	JRY OCCUR	ED
20 03	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. PLACE OF INJUF building, etc. (Sp	iY — At home, farm, stre		M 1 YES 2 ND  281, factory, office  281, LOCATION (Street and Number or Rural Route Number City or Town, State)				
COMPLETED BY PRINCIPLY.	2001	SICIAN: To the best of my kno							suse(s) and manner as stated.
200	296. SIGNATURE AND TITLE OF CERTIFIE Morrow SKE		ind		29c. LICENSE NUN			ed. DATE SI	GNED (Month, Day, Year)
	30. NAME AND ADDRESS OF PERSON W	R.KLETM	on mi	nnt)	803 ED.	MON.	Dsor	BUE.	-21229
	31. DATE FILED (Month, Day, Year)  ADD 06 1993	32. REGISTRAR'S SIG	Danda BO						



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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	

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A. Krasner

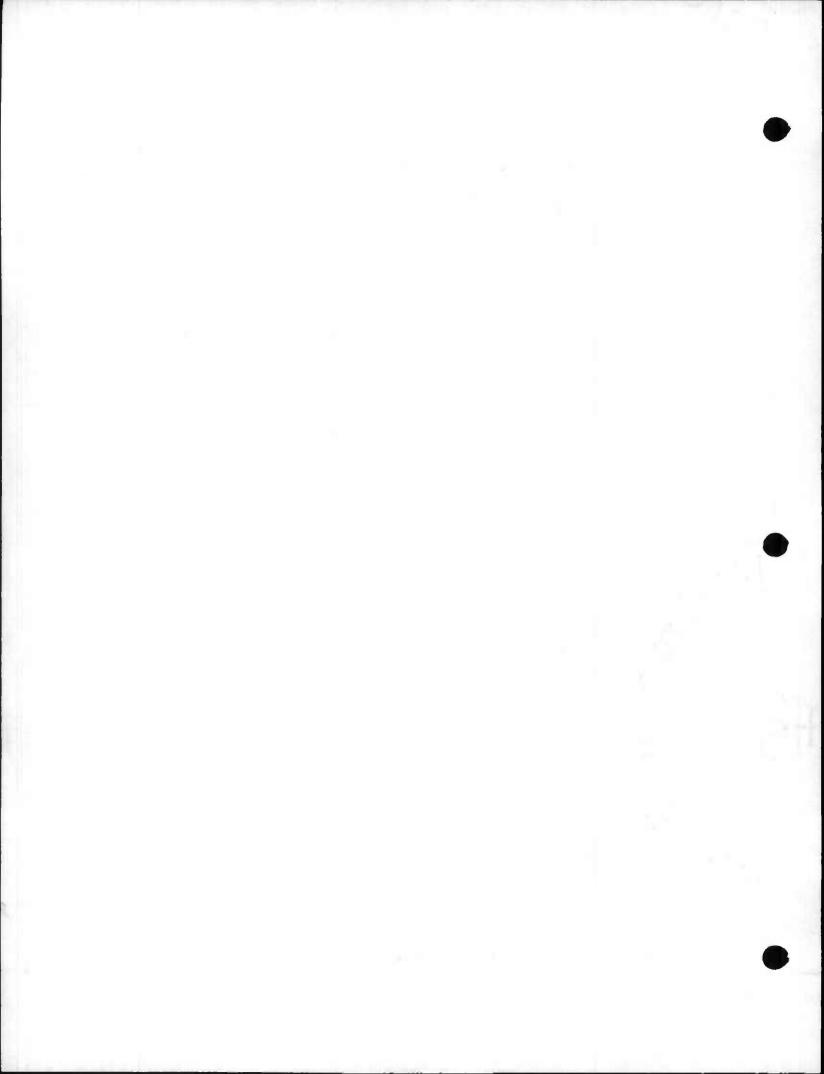
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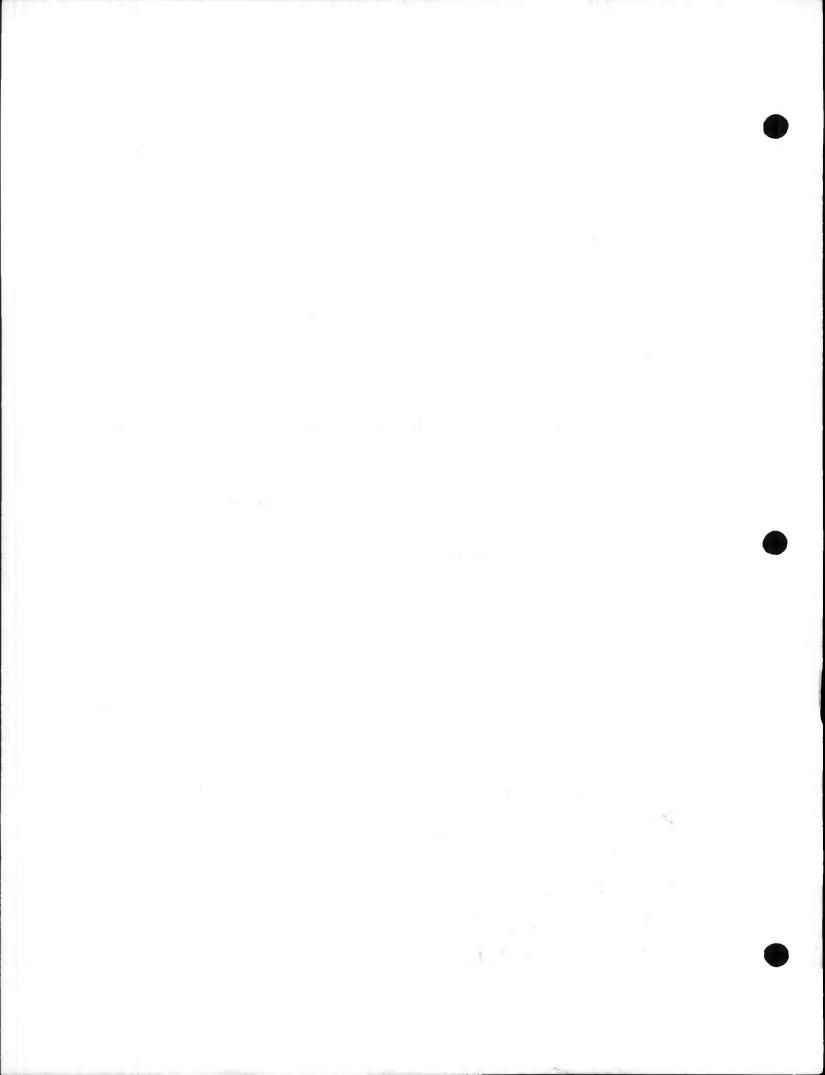
32 REGISTRAR'S SIGNATURE

	FOR	CTATE OF MADY	MD / DEPART	APRIT OF "	PA1911 AND ASS.		3 0	9635				
	1 - STATE REGISTRAR	STATE OF MARYLA	CERTIFIC	ATE OF	DEATH	AL HYGIENE REG. NO.						
	1. DECEDENT'S NAME (First, Middle, Lest)	4. Siste	ie M. Sis	ler		TE OF DEATH	PYEAR 3.	TIME OF DEATH				
1	4. SOCIAL SECURITY NUMBER 217-22-9509	5. SEX 6. AGE (N	41	F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. 7, DA HOURS MH. (M	TE OF BIRTH Onth, Day, Year) 6-27-12	8. BIRTHPL Country)	ACE (State or Foreig				
5	SAINT JOSEP	n Hospital	9	TOW:	R LOCATION OF DEATH	9c. COL	INTY OF DEAT	7				
DIRECTOR	10a. STATE 10b. COUNT	Baltimore	10c. CITY, 1	TOWN OR LOCAT	ESSEX		10	d. INSIDE CITY LIMITS?				
PUNEHAL	100. STREET AND NUMBER 1009 Cherlyn	Road		101	21221	10g, CI1	USA	YES 2 NO				
DY TON	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 XND	If yes, sp	ENDENT OF HISPANIC ORI portly Cuban, Mexican, Puer 2 2 NO Specify:	GIN7 (Specify Yes or No— to Rican, etc.)	14. RACE — Black, V	American Indian, Thite, etc.				
COMPLEIED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 1.2 th	ry (0-12) College (1-4 or 5+) Me. Do M			ON st of working	16b. KIND OF BUSINESS/IN						
5	17. FATHER'S NAME (First, Middle, Last)		House		18. MOTNER'S NAME (First	t, Middle, Maiden Surname)						
TO BE COM	John B. Phil	llips	-		Pearl		-					
	198. INFORMANT'S NAME (Type/Print)  190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Co  Wilford Sisler  1009 Cherlyn Road Baltimore Marylan											
	20 Burlel 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify) Gardens Of Faith Cemetery 4/7/93 Rossville Md/ 21 SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  ConnellyFuneralHome 300MaceAve. 21221  23. PART I. Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cardiec or reepiratory arrest, Approximate											
	shock, or heat/failure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)	Brain	Tumul  CONSEDUENCE OF):	enter the mo	de of dying, such as c	ardiec or reepiratory as	reat,	Approximatinterval Bet Onset and Month				
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEDUENCE DF):  c. DUE TO (OR AS A CONSEDUENCE OF):											
MEDICAL CE	PART II. Other eignificent condition	g ceuse given in Part I.	. 24a, WAS AN AUTOPSY PERFORMED? 24b, WERE AUTOPSY AMALABLE PRK COMPLETION D OF DEATH?									
PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL			26 PI	ACE OF DEATH (Check only	onel	1	☐ YES 2 NO				
200	EXAMINER?	HOSPITAL: 1 N Inpetient 2 ER/Output		THER:	5 🗆 Residence 6 🗆 O							
BY PH	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	RK? 'ES 2 NO	PEŞCRIBE NOW INJURY OC	CURED								
EIED	3 Suicide 6 Could not be 4 Nomicide determined	26a. PLACE OF INJURY building, etc. (Special	— At home, ferm, stre	et, factory, office		OCATION (Street and Number lty or Town, State)	r or Rural Rout	e Number,				
COMPL		ICIAN: To the best of my knowle						nd manner as sta				
H 1	29b. SIGNATURE AND TITLE OF CERTIFIE	~ MD	0 4 1 6 6	ENSE NUMBER 29d. DATE SIGNED (Morrill. Day, Year)  4/66/  4/4/93								
10	30. NAME AND ADDRESS OF PERSON WITH A CONTROL	7620 YUK	TN (ITEM 27) (Type, Pr. Road T	ine) UNSUN	, MD 212	04						

DHMH-16 Rev 1/89



_	REGISTRAR				96111111	TOATE OF	F DEATH		REG. NO.		3 (	
	1. DECEDENT'S NAME (First, A	Middle, Last)	ANINI			IN WILLIAM		MON			YEAR	3. TIME OF OEATH
	BARBARA  4. SOCIAL SECURITY NUMBER	R	ANN 5. SEX	6. AGE (In	yrs. last birthday	AYLOR	IF UNDER 24 HRS.	7. DATI	1 03 OF BIRTH	199		3:20 Z
	218-46-6909		1 🗌 M 2 💢 F	46	YRS.	MONTHS DAYS		(Mor	th, Day, Year) -29-194		Country)	
m	9a. FACILITY NAME (If not Insti	titution, give street and number)				9b. CITY, TOWN	OR LOCATION OF O	EATH		9c. COUNT		
DIRECTOR	609 PARK	AVENU	E			BALT	IMORE			NONE		
18	MARYLAND		TY, TOWN OR LOC ALTIMORE						IOd. INSIDE CITY			
	10e. STREET AND NUMBER	DAL	TIMORE C	. Т Т Т	D1		IOF. ZIP CODE		_	10e. CITIZE		I YES 2 1 NO
FUNERAL	609 PARK AVE	NUE					21201			U.S.		
B	11. MARITAL STATUS  1 Never Married 2 M 3 Widowed 4 Divorce		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES	2 X NO	If yes,	ECENDENT OF HISPA apecify Cuban, Maxica ES 2 NO Specific	in, Puerto		or No— 14	Black, Specify	- American Indian, White, etc. WHITE
ETED		DENT'S EDUC		1	(Give kind of	S USUAL OCCUPAT		16	b. KINO OF BUS	SINESS/INDUS	STRY	
P.E.	Elementary/Secondary (0-1:	2)	College (1-4 or 5	+)	CLERIO	use retired.)	•		HARBOF	R HOSP	ΤͲΔΤ	
COMPL	17. FATHER'S NAME (First, Mick		-				18. MOTHER'S NA	ME (First,		Sumame)		
BE C	WILLIAM M. T						VERNEL			AUSTI		
5	190. INFORMANT'S NAME (Typ MRS. VERNELL		S		526	G ADDRESS (Street BROAD CF	t and Number or Rural REEK DRIV	Route Nur E, S'	nber, City or Town TEVENSV	7 ILLE,	MD.	21666
	20a. METHOO OF DISPOSITIO  1XXBurial 2 Cremation  4 Donation 5 Other (S	3 🗆 Remo	val from State	20b. P	LACE AND DATE	of DISPOSITION	Nama of AL PARK	4%	0/	CATION — CIT		
- 10	21. SIGNATURE OF FUNERAL		ENSEE		N NAVE		AND ADDRESS OF FA					MARYLAN
	22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME  1 SECOND AVE., S.W., GLEN BURNIE, MD.2106											
	23. PART I. Enter the disc	easea, or co art failure. L	omplications the	at coused to	the death. Do			, S.	W., GLE	EN BUR	NIE,	MD.2106 Approximate Interval Between
TIFICATION	23. PART I. Enter the disc	esses, or coart failure. L	DUE TO	OKE ORASAC	ch lina.	not enter tha m	node of dying, suc	, S.	W., GLE	EN BUR	NIE,	MD.2106 Approximate Interval Between
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page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should notified at Pe must by the funeral director, emoval. examiner hours after death. medical in by filled I completely filler the HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within event, in and con to burial, traumatic the attending physician I Mental Hygiene prior to other 0 Injury, been signed by the any shows Dept. certificate h Item 6 marked, with with DIRECTOR; After the hours after death with them 28 is mark TO THE HOSPITAL OF TO THE FUNERAL DE filed within 72 ho

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29b. SIGI

93 09637 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH ™1993 YEAR April 5, Herberta THANNER 3:53 AM 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH
(Month, Day, Year)
JAn. 23, 1908 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign 214-01-1883 85 1 🗌 M 2 🖾 F MAryland 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH FUNERAL DIRECTOR Franklin Square Hospital Rossville Baltimore RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. Baltimore Essex 1 TES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 54 Wiltshire Road 21221 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, Whife, atc. 1 Never Married 2 Married If yee, specify Cuben, Mexicen, Puerto Ri IF YES, GIVE WAR OR DATES 84 1 TES 2 NO Specify Specify: 3 X Widowed 4 Divorced White BE COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade compl Elementary/Secondary (0-12) College (1-4 or 5+) HOusewife 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) James Joaces Geary Emma Knapp 190. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Joan Kugler 801 Geis Circle Glen Bernie Md. 21061 20s. METHOD OF DISPOSITION
12C Burlel 2 Cremetion 3 Removal from State
4 Donetion 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE composition of other classes 4/8/93 Baltimore Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ConnellyFuneralHome 300MaceAve. 21221 Onn 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between **IMMEDIATE CAUSE (Final** Onset and Death disease or condition\_ . Dysrhythmia reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): Coronary Artery Disease; Left Bundle Branch Block; CERTIFICATION Sequentially list conditions, if any, leading to immediate Cardiomegaly cause, Enter UNDERLYING C Systolic Hypertension CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS Chronic Obstructive Pulmonary Disease AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 1 NO DF DEATH? Multiinfarct Dementia 1 | YES 2 | NO Diverticulosis 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 TYES 2 1 NO lent 2 ER/Outpatient 3 DOA

27. MANNER OF OEATH  1 X Netural 5 Pending 2 Accident Investigation	28e. OATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28d. OEŞCRIBE HOW INJURY OCCURED				
3 Suicide 6 Could not be datermined	28e. PLACE OF INJURY — At hor building, atc. (Specify)	me, farm, street, fed	tory, office	281, LOCATION (Street and Number or Rural Route Number, City or Yown, State)			
29a CERTIFIER							

CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner se stated. 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the

				to the cooce(e) and morning	on stated
INTEREST AND THE COLORD					
ATURE AND TITLE OF CERTIFIER		29c. LICENSE NUMBER	2	9d. DATE SIGNED (Month Day Y	(nor)

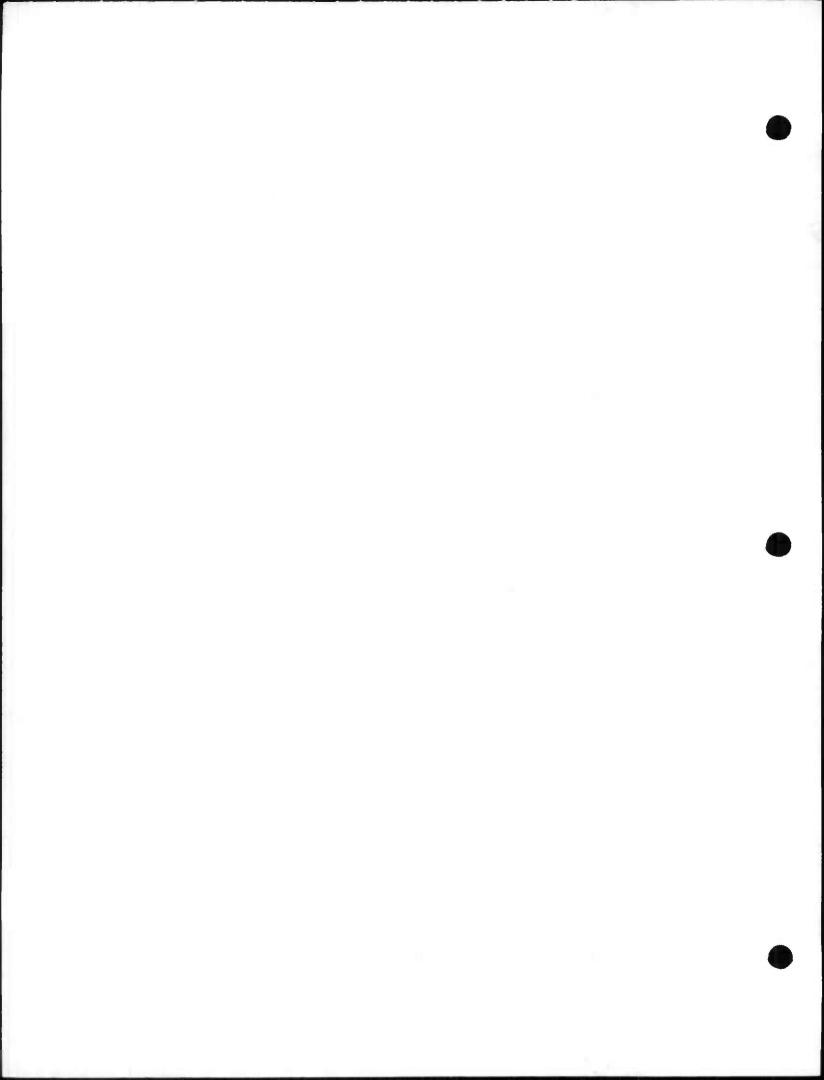
H44037

Bonita Portier, M.D. 9000 Franklin Square Drive, Baltimore, MD 21237

31. DATE FILED (Month, Day, Year) 06 1993

32. REGISTRAR'S SIGNATURE

April



FOR STATE REGISTRAR

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cn	CTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director
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ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 mi	E

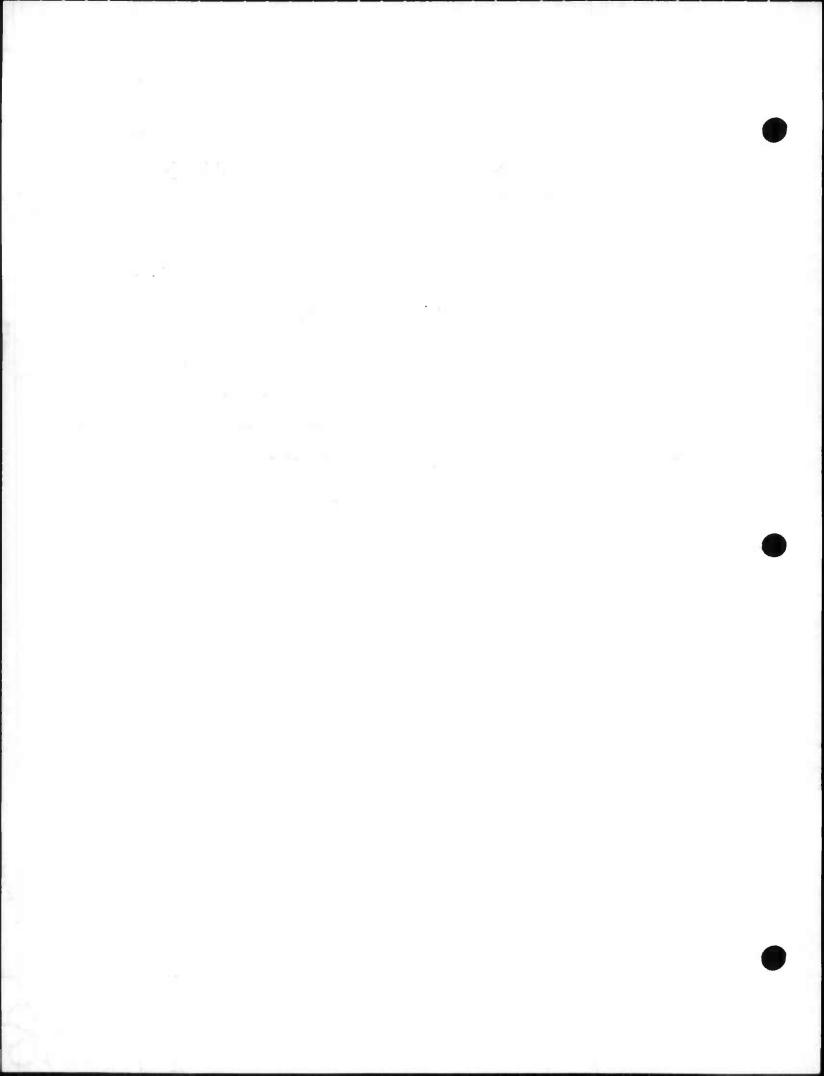
HOSPITAL DR

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DAY DA ALVERDA 40/A NILLIAMS 02 4. SOCIAL SECURITY NUMBER 5 SEY 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign NOV.15, 1912 MARYLAND 1 - M 2 F 80 12 1639 permit. Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH FUNERAL DIRECTOR LIBERTY MEDICAL CENTER BALTIMORE RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE 1 X YES 2 NO 10s. STREET AND NUMBER IN TIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21215 5445 JONOUIL AVENUE U.S. OF A. for use as the burial-transit 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No 14. RACE — American Indian, Black. White, etc. 1 Never Married 2 Marrie FORCES? 1 YES 2 If yes, specify Cubs Specify: BY Specify: BLACK 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grad Elementary/Secondary (0-12) College (1-4 or 5+) detached 8th LAYING OUT PATERNS **CLOTHING FACTORY** at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) HENRY EDWARDS sage 5 should be LAURA EDWARDS BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Floute Number, City or Town, State, Zip Code) 2 LUCILLE NEWTON 5445 JONOUIL AVENUE BALTIMORE, MARYLAND 21215 99 20s, METHOD OF DISPOSITION
1 Surial 2 Cremation 3 Removal from State
4 Donation 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must OATE MT. ZION CEMETERY BALTIMORE, MARYLAND 4/6/93 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY LEWIS T. GWYNN FUNERAL HOME 21215-6393 4517 PARK HEIGHTS AVE. BALTIMORE, MARYLAND or removal Item 23 shows any Injury, or other traumatic event, the medical 23. PART I. Enter the diseases, or complication that caused the death. Do not enter the mode of dying, such as cardiac or reepiratory arrest, shock, or heart fellure. List only one cause on each line. Approximata Interval Between IMMEDIATE CAUSE (Final Onset and Death cremation, disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF) 000 of Health and Mental Hygiene prior to burial, é acute MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING mica. CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMED? 1 TES 2 NO OF DEATH? 1 TES 2 NO PHYSICIAN: Dept. 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATN (Check only one) the State **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA te 5 Residence 6 Other (Specify) 28 is marked, or 27. MANNER OF OEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCUREO death with 1 Natural 2 Acciden 5 Pending 1 YES 2 NO BY Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number City or Town, State) 6 Could not be COMPLETED after 4 Homicide DIREC IMPORTANT: If Item CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated. FUNERAL ( within 72 h MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, BE 로 프로 4/2/ 193 BIKUMES KOYA 0422 M.D 2 3 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) 4306 PHEFELD MB Laurdson-Handell SHE BATE FILED (Month, Day, Year) 06 1993

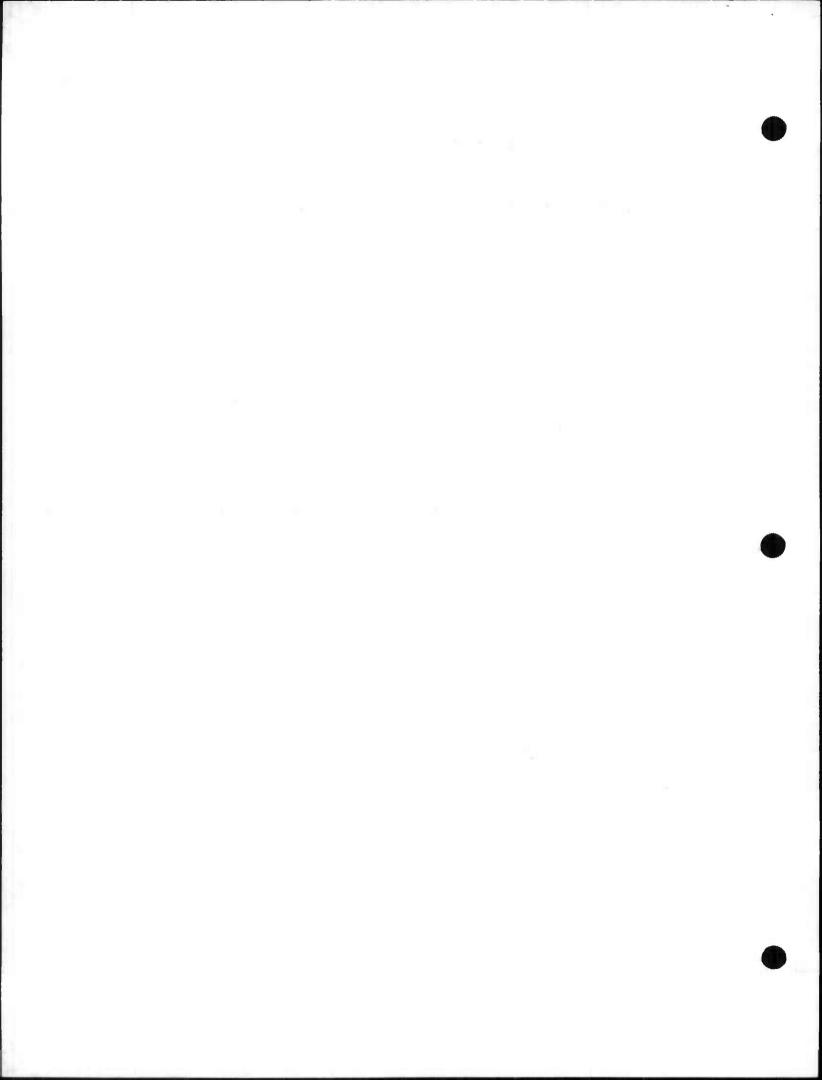
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 93 09638

REG. NO.

CERTIFICATE OF DEATH



		1 - STATE REGISTRAR	STATE OF MARYLANI	D / DEPAR CERTIF	RTMENT OF ICATE OF	HEALTH AN	D MEN1	REG. NO.	93	09639			
		1. DECEDENT'S NAME (First, Middle, Last)  Bessie	Williams					TE OF DEATH	199°	3. TIME OF DEATH			
		4. SOCIAL SECURITY NUMBER 229-36-4010		i. lasi birthday) 4 YRS,	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HR	S. 7. DA		31 8.5	SIRTHPLACE (State or Foreign Country)			
3 should	8	9a. FACILITY NAME (If not institution, give st		- 36	9b. CITY, TOWN	OR LOCATION OF		1-24-2	9c. COUNTY	V A OF DEATN			
2	CTO	Union Memorial Hospital Baltimore Maryland											
. Pages	DIRECTO	10a. STATE 10b. COUNTY			altimo				10d. INSIDE CITY V LIMITS? T YES 2 NO				
sit permi	RAL	104. STREET AND NUMBER 816 Argonne	Dr.		1	01. ZIP CODE 21218			10g. CITIZEN OF WHAT COUNTRY?				
-0020 ing physician. the burial-trans	BY FUNER	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2/ IF YES, GIVE WAR OR DATES	ARMED	13. WAS DE		PANIC ORIGINAL PUBLIC SCIPY:	GIN? (Specify Yes to Rican, etc.)	or No — 14.	RACE — American Indian, Black, White, etc.			
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit permit. Pages 1, notified at once.	COMPLETED	15, DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) 8th	ATION 16a. completed) College (1-4 or 5+)	DECEDENT'S (Give kind of life, Do NOT u	USUAL OCCUPAT work done during n se retired.)	TION nost of working		John H	NESS/INDUST				
MARYLAND 21 retained by the hospital or 5 should be detached for utilified at once.	BE COM	17. FATHER'S NAME (First, Middle, Lest) Ben Luke Will	iams			18. MOTNER'S	NAME (Firs	t, Middle, Maiden S		- 1103p1041			
E, MAR y be retained rage 5 should be notified	TO B	19a. INFORMANT'S NAME (Type/Print) Curtis Lee Wi	lliams					mber, City or Town, folk,					
AORE le 6 may rector, pa		20a. METNOD OF DISPOSITION  1 W Burlet 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	val from State 20b. PLA	CEANDDATE	of disposition (f	Name of Netery	D	- 1	esvil	or Town, State 1e, MD			
BALTIMORE, ter death. Page 6 may be the funeral director, page oval.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  WM C. MARCH FH/1101 E. NORTH AVE.											
24 hours at filled in by ion, or remother		23. PART I. Enter the diseasea, Dr c ehock, pr haert failure. I IMMEDIATE CAUSE (Final disease pr condition resulting in death)	proplications that coursed the cite only one cause on each	line	not enter the m	ode of dying, a	uch aa ce	erdiec or reepire	etory arreat,	Approximete Interval Batween Onset and Death			
SOX 68 ate be execut ysician and c prior to burit traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events  Disabetic Kctoacidos: S  Due to (or as a consequence of):  H. D. Therm. Ca.  Due to (or as a consequence of):											
OS, P.O. Be to death certificate the attending physiometral Hygiene principle, or other triplery, or other t	CERT	resulting in death) LAST	a. Preumonia										
RD at the by the and M	MEDICAL	PART II. Other significant conditions	contributing to dasth but not resulting in the underlying cause given in F					24a. WAS AN A PERFORM 1 YES 2 [	IED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?  1  YES 2 NO			
L law law bept 23	PHYSICIAN: MEDI	25. WAS CASE REFERRED TO MEDICAL											
F VITA SICIAN: The certificate h the State (	SICI	EXAMINER?	HOSPITAL:	3 🗆 DOA	OTHER:	me 5 Residen							
	ВУ РН	27. MANNER OF DEATH  1. Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	URY W	JURY AT ORK? YES 2 NO	28d. D	EȘCRIBE HOW IN	JURY OCCURE	D			
MISION THENDING REPORTS After the state of t		3 Suicide 8 Could not be 4 Homicide detarmined	28a. PLACE OF INJURY — As building, atc. (Specify)	t home, tarm,	street, factory, offi	ca		OCATION (Street an ity or Town, State)	d Number or Re	ural Route Number,			
A SE SE SE SE SE SE SE SE SE SE SE SE SE	COMPLETE		IAN: To the best of my knowledge : On the beals of examination and							use(a) and manner as stated.			
TO THE HOSPI TO THE FUNER DE filed within	H	396. BIGNATURE AND TITLE OF CERTIFIER	land D			29s. LICENSE )	NUMBER		29d. DATE SIG	NED (Month, Day, Year)			
	2	30. NAME AND ADDRESS OF PERSON WHO			Print) Menorio	1 2 11	imaic	m ()	1451	11 3 (11)			
3		31. DATE FILED (Month, Day, Year)  APR 06 1993	32. REGISTRAR'S SIGNATUR	E	HICKOLD	Dal	WOLG	11/4					

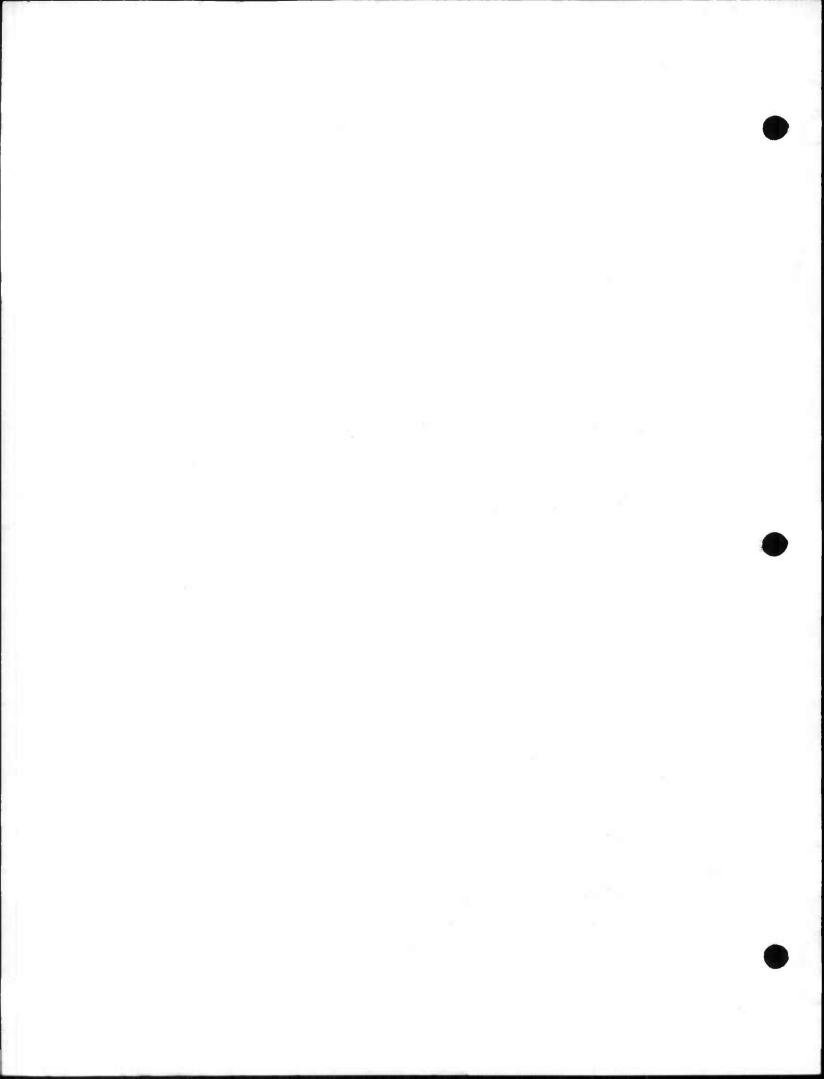


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		1. OECEDENT'S NAME (First,	<b>9</b> <sub>0</sub>						DEA			OF DEATH		3.	TIME OF DEATH
		MARY E		MORTH							MONT	3 3		YEAR 3	09.20PM
		4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. I		IF UNDER	DAYS	IF UNDER	MIN.	(Mon	OF BIRTH		8. BIRTHPL Country)	ACE (State or Foreign
should		214 62 204		1 M 2 KF		YRS.		111		1,772.60		-30-	2		1and
3 sho	œ	94. FACILITY NAME (If not ins.	MER	BALTIMORE CITY					9c. COUNTY OF DEATH						
1, 2,	57	RESIDENCE OF DECI		- CEN	787		DI	16.7	MOK	E	اب	14	===		==
	H		10b. COUNTY			10c. Cl	TY, TOWN	OR LOCA	TION					10	d. INSIDE CITY
permit. Pages	۵	Maryland							,				LIMITS?		
t per	RAL	10s. STREET AND NUMBER						10	H. ZIP COD				10g. CITIZEN OF WHAT COUNTRY?		
020 physician. bunal-transit	NER	4216 Morr	ison (							225				.S.A.	
D20 ohysic	FUN	1 Never Married 2 A	Married		YES 2 3			If yes, sp	pecify Cube	ın, Mexica	in, Puerto	N? (Specify Yes Rican, atc.)	or No-	14. RACE — Black, W	American Indian, /hite, etc.
215-0020 attending physician. se as the bunal-tran	B≼	3 Widowed 4 Divort	MAR OR DATES			1 TYES	2 NO	Specif	y:		- 1	Specify:	White		
21215-0020 al or attending physic for use as the burial			DENT'S EDUC		16a. D	ECEDENT'S	USUAL O	CCUPATI	ON		168	. KIND OF BUS	INESS/INDU	ISTRY	MITCE
	COMPLET	Elementary/Secondary (0-	12)	College (1-4 or 5	+)			during mo	ost of workin	ng					
the hospital or detached for u	MP	12th Grade			I	louse	wife					Home 1	Maker		
YLAN by the hos be detach at once.		17. FATHER'S NAME (First, Mid		oseph I	Dwyer				18. MOT	HER'S NA		Middle, Maiden	Sumame)		
MARYL retained by 5 should be notified at	BE	19e. INFORMANT'S NAME (Ty)				VIII ON THE REAL PROPERTY.									
	2	Marian Hi	llis			4216	Morr	isor	ond Number	r or Aural i		altimor			nd 21225
FOR e 6 ma rector, p		20e. METHOD OF DISPOSITION  1 Densition   Densition	3 🗆 Remo	rval from State	20b. PLACE cometery. C Balt	and date	of bispos	ion	ame of al Ce	em.	4/		cation — c ltimo		sum. Maryland
ALTIN death. Pag tuneral di f. examiner		21. SIONATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A.													
		Hann	01	M Sna	mina	, sh	6 4	001	Ritc	hie	Hwv.				21225
B nours after d in by the or removal.		23. PART I. Enter the dis	eeses, or c	omplications the	ot caused the d	eath. Do	not anter	the mo	ode of dy	ing, suc	h as can	diac or reaple	ratory arre	at,	Approximate
	- 1	IMMEDIATE CAUSE (Fine		nat amily Dile cet	use on each iin										Onset and Daath
		disease or condition resulting in death)	<b>&gt;</b>	SE	PSIS										
N 8 5 - 61				DUE TO	(OR AS A CONSE	QUENCE O	F):			-					
Secu xecu and and pur	ON	Sequentially list condition		DUE TO	(OR AS A CONSE	OUENCE O	E).								
Series of Series	CERTIFICATION	If any, leeding to immedicause. Enter UNDERLYIN	IG		(		. ,.								
.O. B. certificate ding physical physical certificate or certifica	F	CAUSE (Disease or Injury that initiated events	·	DUE TO	(OR AS A CONSE	OUENCE O	F):	_							
S, P.O. I be death certificative attending ph Mental Hygiene jury, or other	FH	resulting in death) LAST													
		PART II. Other significant	t conditions	contributing to	death but not	resulting	In the ur	derivin	G COURS (	aluan In	Dord I	24a, WAS AN	ALITONON	T 045 110	
m = 65 -	MEDICAL							out you	3 02000 1	Archi III	rait i.	PERFOR	MED?	AM	RE AUTOPSY FINDINGS ALABLE PRIOR TO MPLETION OF CAUSE
Signed Health a											_	1 TYES 2	NO	OF	DEATH?
St of Ge											-			1 (	YES 2 X NO
23 E	X	25. WAS CASE REFERRED TO	MEDICAL					26. PI	LACE OF D	EATH (Ch	eck only or	ne)			
or Item	PHYSICIAN:	EXAMINER?  1 YES 2 NO		HOSPITAL:	ER/Outpatient	B DOA	OTHER 4 Num		ne 5 🗆 Ra	sidence	8 Othe	er (Specify)		_	
No. 107 AP 44	E	27. MANNER OF DEATH		28e. DATE OF (Month, D		26b. Till	E OF JURY	28c. fNJ WC	JURY AT		28d. DE	SCRIBE HOW IN	JURY OCCU	IRED	
	₽	recovere	ending vestigation				М	1 🗆	YES 2	NO					
ISIC TTENDI TTOR: A after d	0		ould not be starmined	28e. PLACE O building,	OF INJURY — At hatc. (Specify)	ome, farm,	street, fact	ory, offic	:•			ATION (Street e or Town, State)	nd Number o	r Rural Route	Number,
DIV DIREC DIREC Hours	PE	29e. CERTIFIER (Check only	YING PHYSIC	IAN: To the best of	my knowledge, d	eath occurr	ed at the t	lma, date	end place.	end due	to the car	use(e) end man	ner se state	1.	
THE HOSPITAL THE FUNERAL, filed within 72 P	COMPLET	one) 2 MEDIC	AL EXAMINER						feath occur	red at the	tima, date				d manner as stated.
TO THE HOSPI TO THE FUNER be filed within IMPORTANT:	TO BE	Abjection V	beston	nehan			een)		29c. LICE	NSE NUM	ABER		29d. DATE	SIGNED (Mo	onth, Day, Year)
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  OF VEELAWACHAMEN (9/49)														
		31. DATE FILED (HOND), POO	m 4	22 569 33	HE SALVESTE	5	-/	_			-		_		
		APK 00 133	0		•										

Pages 1, 2, 3 should

	REGISTRAR	CE	ERTIFICA	TE OF DEATH		REG. NO.			
1	1. DECEDENT'S NAME (First, Middle, Last)	./			2. DATE O		YEAR	3. TIME OF DEATH	
	William	H. 0,4	ite		4	3	93	7:45 PM	
	4. SOCIAL SECURITY NUMBER  2/4-18-6852  1 ☑ M	2   F   6. AGE (In yrs. lest	t birthday) IF UN YRS. MONTH	DER 1 YEAR IF UNDER 24 HRS. IS DAYS HOURS MIN.	7. DATE Of (Month,	BIRTH Day, Your) 23-/9	8. BIRTH Count	1PLACE (State or Foreign (Y)	
TOR	98. FACILITY NAME (If not institution, give street and nu.  Sunan Horse ST	imber) tal of Bal	6. 9b. C	Baltimor			Ma		
BY FUNERAL DIRECTOR	10a. STATE 10b. COUNTY	•	Ba /	N OR LOCATION				10d. INSIDE CITY LIMITS?	
IAL I	10e. STREET AND NUMBER	м Л	- 4 /	101. ZIP CODE		1	0g. CITIZEN OF V	1 XYES 2 NO	
J. NE.	3402 Kosedale	DECEDENT EVER IN U.S. ARI	MED I	UZI	5	(Caralla Mara	4.	5.19	
	1 Never Married 2 Married FORG	CES? 1 A YES 2 N S, GIVE WAR OR DATES	RMED   13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, specify Cuban, Mexican, Puerto Rican, etc.)   1   YES 2   NO Specify:   Specify:					E — American Indian, k, Whita, etc. hy: Black	
COMPLETED		(1-4 or 5 +)	CEDENT'S USUAL we kind of work do Do NOT use retire	OCCUPATION ne during most of working it.)	18b. K	IND OF BUSIN	ESS/INDUSTRY		
AMC.	129 (ong Shore nun  17. FATHER'S NAME (First, Middle, Last)  18. MOTHER'S NAME (First, Middle, Maiden Surname)								
BE C	Wm White			Mane	ET	16 3	name)		
5	190. INFORMANT'S NAME (Type/Print)  BOLL ULL + 0	196	MAILING ADDR	Rosedale.	Route Number	City or Town, S		21215	
	20a. METHOD OF DISPOSITION 1 METHOD OF DISPOSITION 2 Ramoval from		AND DATE OF DISF	OSITION/Name of	DATE		TION City or To		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  23. NAME AND ADDRESS OF FACILITY  24. NAME AND ADDRESS OF FACILITY  25. NAME AND ADDRESS OF FACILITY  26. NAME AND ADDRESS OF FACILITY  27. NAME AND ADDRESS OF FACILITY  28. NAME AND ADDRESS OF FACILITY  29. NAME AND ADDRESS OF FACILITY  21. NAME AND ADDRESS OF FACILITY  21. NAME AND ADDRESS OF FACILITY  21. NAME AND ADDRESS OF FACILITY  22. NAME AND ADDRESS OF FACILITY  23. NAME AND ADDRESS OF FACILITY  24. NAME AND ADDRESS OF FACILITY  25. NAME AND ADDRESS OF FACILITY  26. NAME AND ADDRESS OF FACILITY  27. NAME AND ADDRESS OF FACILITY  28. NAME AND ADDRESS OF FACILITY  29. NAME AND ADDRESS OF FACILIT								
	Tala March March 4300 Walnsh Sue								
	23. PART I. Enter the diseases, or complicat abook, or heart failure. List only IMMEDIATE CAUSE (Final disease or condition resulting in death)	DUE TO (OR AS A CONSECU	DIENCE OF				ory arrest,	Approximate Interval Between Onset and Daath	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  b. Due to (or as a consequence of):  Due to (or as a consequence of):								
CER	d								
DICAL	PART II. Other algnificant conditions contributing to death but not result			a undariying cauaa givan in Part I. 24a. WAS AN-AUTOP: PERFORMED?  t ☑ YES 2 ☐ NO			D?	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
: ME	1 UYES 2 MO								
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	20. FEACE OF DEATH [CHECK ONLY ONE)							
YSI	t YES 2 NO t Imper	tient 2 ER/Outpatient 3		ER: lursing Home 5 - Residence	6 Other (	Specify)			
ву Рн	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28b. TIME OF INJURY M				E HOW INJURY OCCURED			
	3 Suicide 6 Could not ba 4 Homicide determined	PLACE OF INJURY — At hor building, etc. (Specify)	home, farm, street, lactory, offica 261. LOCATION (Street an City or Town, State)			ION (Street and Town, State)	nd Number or Rural Route Number,		
COMPLETED	29a. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(a) end manner as stated.  2 MEDICAL EXAMINER: On the basele of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) end manner as stated.								
H H	SIGNATURE AND TITLE OF CHATTER  29c. LICENSE NUMBER  29d. DATE SIGNED (Month, Day, Year)  43/93								
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)								
	31. DATE FILED (Month, Day, Year) 32. R	NEGISTRAR'S SIGNATURE							
	APR 06 1993	Davidson-Rande	R.						



93 09642

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR		ATE OF DEATH	REG. NO.					
	1. DECEDENT'S NAME (First, Middle, Last) GEORGE	ne i	WANER	2. DATE OF DEATH DAY	- 9 YEAR	3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER   6. AV 2   F	85 YRS. MO	UNDER 1 YEAR IF UNDER 24 HRS.  YTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Mogth, Day, Veer) 12/19/19	907 8. BIRT	THPLACE (State or Foreign TARYLAND			
OR	9a. FACILITY NAME (If not institution, give street and number)  LEVINDALE HEBREW HOME  9b. CITY, TOWN OR LOCATION OF DEATH  BALTIMORE								
DIRECTOR	10a. STATE 10b. COUNTY MARYLAND BALTIMORE		OWN OR LOCATION TIMORE			10d. INSIDE CITY LIMITS? 1 YES 2 JANO			
FUNERAL	10e. STREET AND NUMBER 4607 HORIZON CIR., APT. 10	)1	10f. ZIP CODE 21.208		10g, CITIZEN OF USA	WHAT COUNTRY?			
BY FUN	11. MARITAL STATUS  1 Never Married 2 Married  XX Widowed 4 Divorced  12. WAS DECEDENT EVER FORCES? 1 YES, GIVE WAR O	ES 2 NO	13. WAS DECENDENT OF HISPAN If yes, specify Cuban, Mexica 1 YES 2 NO Specify	n, Puerto Rican, etc.)	Yea or No.—  14. RACE — American Indian, Black, Whita, etc.  Specify:  WHITE				
COMPLETED	15. DECEDENT'S EOUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  1.2  16a. DECEDENT'S (Give kind of life. Do NOT u BUYER)		JAL OCCUPATION done during most of working tired.)		BUSINESS/INDUSTRY  ZIN'S DEPT. STORE				
	17, FATHER'S NAME (First, Middle, Last) ABRAHAM WANER		16. MOTHER'S NA	ME (First, Middle, Maiden S (UNKNOWN)	urname)				
TO BE	194. INFORMANT'S NAME (Type/Print) ALAN D. WANER	196. MAILING AD	DRESS (Street and Number or Rural HIDDENLAKE DR	Route Number, City or Town,		TT 60090			
	20a. METHOD OF DISPOSITION 1 [X] Burlal 2 Cremetton 3 Removal from State 4 Donation 5 Other (Specify)	20b. PLACE AND DATE OF of cemetary, crematory or SHAAREI	DISPOSITION (Name	DATE 20c. LOC		- City or Town, Stata			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  SOL LEVINSON & BROS., INC.  6010 REISTERTOWN RD. BALTO., MD. 21215								
CERTIFICATION	Sequentielly list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Risease or Injury.	AS A CONSEQUENCE OF:	0 0 1		etory arrest,	Approximate interval Between Onset and Death We sel			
	thet initiated events resulting in death) LAST								
PHYSICIAN: MEDICAL	PART II. Other aignificent conditions contributing to des	th but not resulting in t	he underlying cause given in	Part I. 24e. WAS AN A PERFORE  1 YES 2	WED?	4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO			
ICIAN:	26. WAS CASE REFERRED TO MEDICAL EXAMINER?  26. PLACE OF DEATH (Check only one)  OTHER:								
	1   YES 2   MO								
TED BY	2 Accident Investigation 3 Suicide 8 Could not be detarmined 28e. PLACE OF IN. building, etc.	nd Number or Rura	al Route Number,						
COMPLETED	29a. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.  2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.								
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER  296. LICENSE NUMBER  D 2 7 3 4								
_	Jo. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (TEM 27) (Typo, Print)  Tray H (opelay P. M. 5310 Old Cont Road suite 201 Rendallitous MD 21133								
	31. DATE FILED (Month, Day, Year)  32. REGISTRAR'S  33. REGISTRAR'S  4. APR = 6 1993	SIGNATURE AND AND AND AND AND AND AND AND AND AND							

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2. Thours after death. Page 6 may be retained by the hospital or attending physical THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remonal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

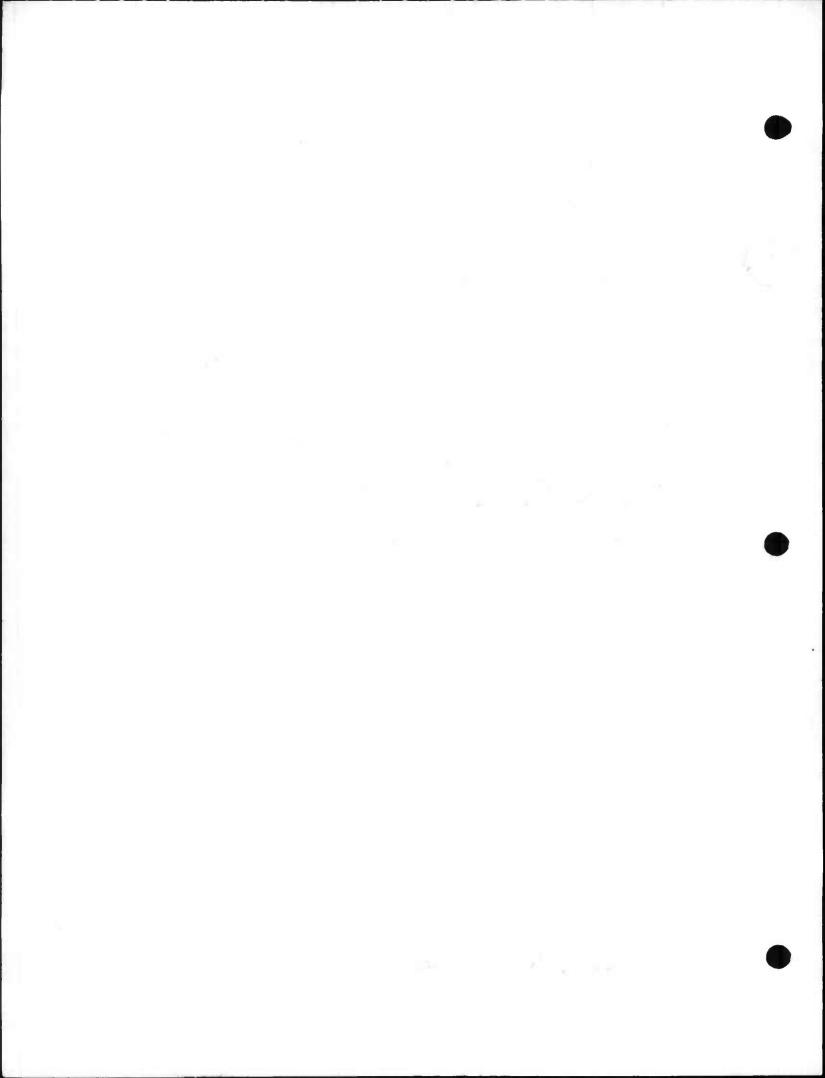
DHMH-16 Rev 1/89

APRIL THE COLUMN STATE AND

DIVISION OF VITAL RECORDS, P.O. BOX 68760,	BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physical	xirs after death. Page 6 may be retained by the hospital or attending physio
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-the be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	In by the funeral director, page 5 should be detached for use as the burial-III in removal.

		FOR STATE REGISTRAR	STATE OF MARYLA	AND / DEPARTM	MENT OF H	IEALTH AND N	IENTAL HYGIEN	-/ \	3 09643
	į	1. DECEDENT'S NAME (First, Middle, Last)	LI IV	REBA		DER)	2. DATE OF DEATH MONTH DA		150 PM
DI.	1	4. SOCIAL SECURITY NUMBER 214-14-4916	1 🗆 M 2 💢 F		IF UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH		BIRTHPLACE (State or Foreign Country) MARYLAND
, z, s snould	TOR	99. FACILITY NAME (If not institution, give s ST. AGNES HOSPIT.  RESIDENCE OF DECEDENT		91	0	MORE	АТН	9c, COUNTY	/ OF DEATH
CO.	DIRECTOR	10e. STATE 10b. COUNT MARYLAND	Y		TOWN OR LOCAT	TON			10d, INSIDE CITY LIMITS? 1 X YES 2 NO
	FUNERAL		., APT. 5-N		101	21229		USA	N OF WHAT COUNTRY?
life punia	BY	11. MARITAL STATUS 1 Never Married 2 Married 3 N Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	If yes, sp	ENDENT OF HISPANI ecify Cuban, Mexican, NO Specify:			BACE — American Indian, Black, White, atc. Specify: WHITE
200 101 102	APLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	JCATION e completed) College (1-4 or 5+)	18a. DECEDENT'S USI (Give kind of work life. Do NOT use n HOUSEWIF	rk done during mo. retired.)	ON st of working	AT HOME		TRY
at once.	E COMPL	17. FATHER'S NAME (First, Middle, Last) BORIS FRE	EDMAN			18. MOTHER'S NAM ELLA	E (First, Middle, Melden :	Surname) RICHMOI	ND
e notified	TO 8	190. INFORMANT'S NAME (Type/Print) MRS. ELLEN ABENDS	CHOEN		DDRESS (Street a	DUNDAL	oute Number, City or Town	n, State, Zip Co	ide)
r must be		Re. METHOD OF DISPOSITION  Burial 2   Cremation 3   Rem  Donation 6   Other (Specify)	noval from Stata cemes	PLACE AND DATE OF D etery, cremetory or other FRIEDEL M	ARYLANI	LODGE	DATE 20c. LOC 4/1/93 RC	CATION — City	y or Town, Stata E, MD
al. examiner		21. SIGNATURE OF FUNERAL REPIVICE LIK	O Leu	vis	SOL LE			VC.	
if, cremation, or removal event, the medical		23. PART I. Enter the diseases, or shock, or heert failure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)	Bronchopne	och ilne.	enter the mo	de of dying, auch	ae cardiac or respin	ratory arreat	t, Approximate interval Between Onset and Death
Mental Hygiene prior to bunal, cremation, ijury, or other traumatic event, the	ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	b	CONSEQUENCE OF):					
tal Hygiene p	CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A C	CONSEQUENCE OF):					
state Dept. of Health and Mental	MEDICAL	PART II. Other algnificent condition	a contributing to death but	t not resulting in t	the underlying	; ceuee given in P	PERFORI  1 DXYES 2	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 X YES 2 NO
State Dep	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO	HOSPITAL: 1 Propertient 2 ER/Outpet		THER:	ACE OF DEATH (Chec			
€ 0	РНУ	27. MANNER OF DEATH  1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	OF 28c, INJU	e 5 Residence 8 URY AT RK? /ES 2 NO	28d. DESCRIBE HOW IN	JURY OCCUR	IED
after d	ETED BY	2 Accident Investigation 3 Suicida 6 Could not be 4 Homicide datermined	28a. PLACE OF INJURY — building, atc. (Specify	- At home, lerm, streety)			281, LOCATION (Street as City or Town, State)	nd Number or F	Rural Route Number,
2 =	COMPLE	One) 2 MEDICAL EXAMINE	ICIAN: To the bast of my knowled						ause(s) and manner as stated.
be filed within IMPORTANT:	TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER	Dicken, In			29c. LICENSE NUMB	DER		IGNED (Month, Day, Year) 31–93
		30. NAME AND ADDRESS OF PERSON WHO	EN, M.D ST	. AGNES H		L - 900 C	CATON AVE.	BALTO	)., MD. 21229
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNAT	TURE					

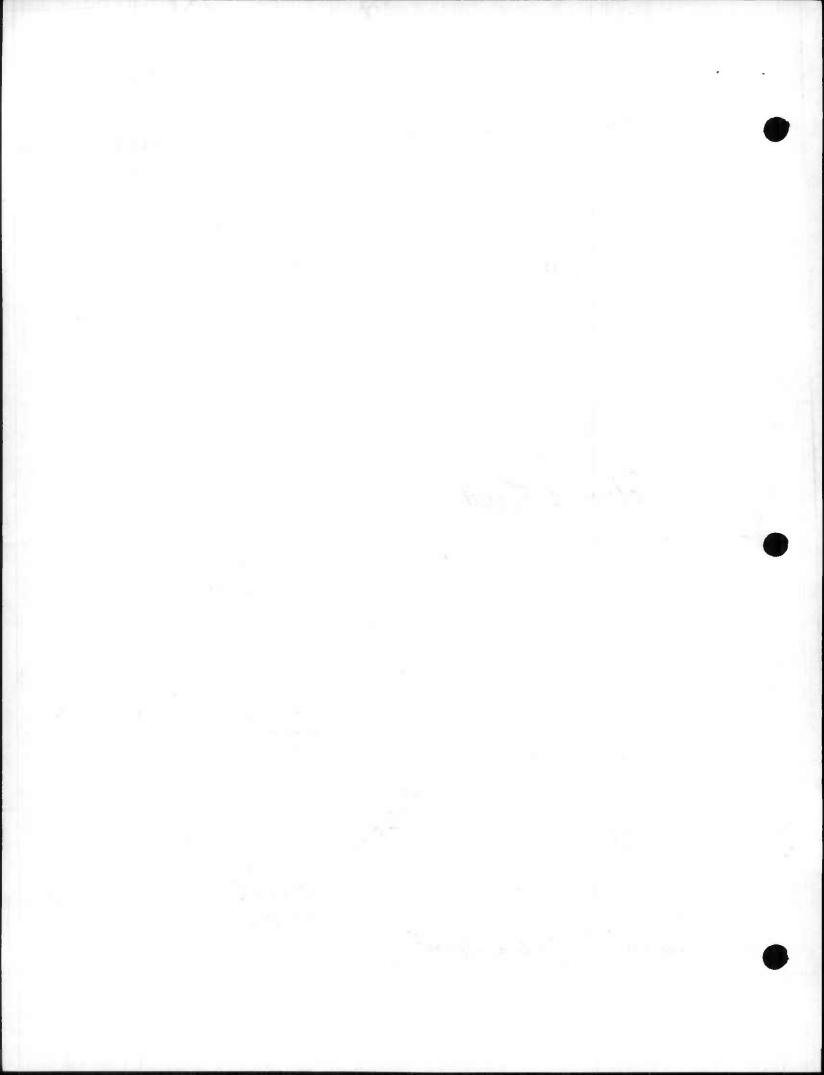
OHMH-16 Rev 1/89



	REGISTRAR		CENTIFI	CATE OF DEATH	REG. NO	).					
	1. DECEDENT'S NAME (First, Middle, Last)  Janet	s. White	- War	nick	2. DATE OF DEATH	MY 0   YEA	3. TIME OF DEATH				
	4. SOCIAL SECURITY NUMBER 219-60-5469		E (In yrs. lest birthday)	IF UNDER 1 YEAR IF UNDER 24 HRI MONTHS DAYS HOURS MIN	Allenth Charles March	0.00	ATHPLACE (State or Foreign Lines of The Market of The Mark				
	Se. FACILITY NAME (If not institution, give	street and number)		9b. CITY, TOWN OR LOCATION OF		9c. COUNTY OF					
HOL	FRANCIS SCOTT	KEY MEDIC	AL CENTE	R BALTIMOR	E						
DIMECTOR	10e. STATE 10b. COUNT	BALTIMORE		TIMORE			10d. INSIDE CITY LIMITS? )([X] YES 2 [ NO				
- 1	3706 NORTH	POINT BLV	D.	101. ZIP CODE 21222		USA	F WHAT COUNTRY?				
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2/1/(Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES	S 2 ( )X(O	13. WAS DECENDENT OF HIS If yes, specify Cuber, Mei 1 VES NO Sp	rican, Puerto Rican, etc.)	В	ACE — American Indian, lack, White, etc.				
ETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12)	le completed)	16e. DECEDENT'S U (Give kind of wo life. Do NOT use	USUAL OCCUPATION ork done during most of working a retired.)	16b. KIND OF BU	JSINESS/INDUSTR	4				
COMPL	.1.2	Coflege (1-4 or 5+)	ENGINEE	RING TECH.		EERING					
BE CO	17. FATHER'S NAME (First, Middle, Lest) FRANK WHITE	, SR.		BETTY	JEAN MCC.	ARTER					
5 B	190. INFORMANT'S NAME (Type/Print) THOMAS W. WA	RNICK, JR.		NORTH POINT		wn, State, Zip Code)					
	20a. METHOD OF DISPOSITION	20	06. PLACE AND DATE OF	F DISPOSITION (Name of	DATE 20c. L	DCATION — City or	Town, State				
	Commetted 2 Cremetted 3 Removal from State  4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LICENSEE  Commettery or other place)  CEMETERY 4/4/93 DARLINGTON, MD. 2  22. NAME AND ADDRESS OF FACILITY										
21. SIGNATURE OF FUNERAL SERVICE LICENSEE    ARKINS F.H.INC., DELTA, PA., 17											
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	b. Metusto Due to (or as	A CONSEQUENCE OF)  A CONSEQUENCE OF)  A CONSEQUENCE OF)	on cancer -	to lung/	liver	24 h				
	resulting in death) LAST										
CERI	resulting in death) Exs.	d									
N: MEDICAL CERT	PART II. Other algnificant condition	d contributing to death	but not resulting in	n the underlying ceuse given		RMED?	AMILABLE PRIOR TO COMPLETION OF CAL OF DEATH?				
SICIAN: MEDICAL CERT	PART II. Other aignificant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?	NOSPITAL:		28, PLACE OF DEATH OTHER:	PERFO 1 YES  (Check only one)	RMED?	AMILABLE PRIOR TO COMPLETION OF CAL OF DEATH?				
PHYSICIAN: MEDICAL CERT	PART II. Other algnificant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1   YES 2   NO  27. MANNER OF DEATH		ripatient 3 □ DOA	28. PLACE OF DEATH OTHER: 4   Nursing Home 5   Residen	PERFO 1 YES  (Check only one)	PIMED?	AMILABLE PRIOR TO COMPLETION OF CAI OF DEATH?  1 YES 2 TONC				
BY PHYSICIAN: MEDICAL CERT	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation	MOSPITAL: 1 Impetient 2 = ER/Out 28e. DATE OF INJURY (Month, Day, Vear) 28e. PLACE OF INJUR	ripatient 3 DOA 28b. TIME INJU	28. PLACE OF DEATH OTHER: 4   Nursing Home 5   Resident C OF   28c. INJURY AT   WORK? 1   YES 2   NO	(Check only one)  ce 6 Other (Specify)  28d. DESCRIBE HOW	INJURY OCCURED	AMILABLE PRIOR TO COMPLETION OF CAI OF DEATH?  1 YES 2 VAC				
ED BY PHYSICIAN: MEDICAL	PART II. Other algnificant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation  2 Accident Investigation  3 Suicide 8 Could not be determined	MOSPITAL: 1 Inpetient 2 ER/Out 28s. DATE OF INJURY (Month, Day, Vear) 28s. PLACE OF INJURY	ripatient 3 DOA 28b. TIME INJU	28. PLACE OF DEATH OTHER: 4   Nursing Home 5   Resident C OF   28c. INJURY AT   WORK? 1   YES 2   NO	(Check only one)  ce 6 Other (Specify)  28d. DESCRIBE HOW	INJURY OCCURED	AMILABLE PRIOR TO COMPLETION OF CALOF DEATH?  1 YES 2 WHO				
ETED BY PHYSICIAN: MEDICAL	PART II. Other algnificant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	MOSPITAL: 1   Impatient 2   ER/Out 28s. DATE OF INJURY (Month, Day, Vesr) 28s. PLACE OF INJUR building, stc. (Sp.	ripatient 3 □ DOA   28b. TIME   INJU   RY — At home, ferm, streedly)	28. PLACE OF DEATH OTHER: 4   Nursing Home 5   Resident C OF   28c. INJURY AT   WORK? 1   YES 2   NO	(Check only one)  ce 6 Other (Specify)  28d. DESCRIBE HOW  26f. LOCATION (Street City or Town, State due to the cause(s) and ma	INJURY OCCURED and Number or Rui	AMILABLE PRIOR TO COMPLETION OF CAL OF DEATH?  1 YES 2 THO				
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERT	PART II. Other algnificant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation  2 Accident Investigation  3 Suicide 8 Could not be determined  290. CERTIFIER (Check only 2 MEDICAL EXAMINER)  29b. SIGNATURE AND TITLE OF CERTIFIER	NOSPITAL:  1 Nopelent 2 = ER/Out  28e. DATE OF INJURY (Month, Day, Vear)  28e. PLACE OF INJURY building, stc. (Sp.  SICIAN: To the best of my knovier:  On the besis of examinations.	ripatient 3 DOA 28b. TIME INJU RY — At home, ferm, strecity) wiedge, death occurred ion and/or investigation	28. PLACE OF DEATH OTHER: 4   Nursing Home 5   Resident OF WORK? AND WORK? 1   YES 2   NO Irrest, factory, office  d at the time, date and place, and on, in my opinion, death occurred at  29c. LICENSE	(Check only one)  ce 6 Other (Specify)  28d. DESCRIBE HOW  28f. LOCATION (Street City or Town, State  due to the cause(s) and muthe time, data and place, a	INJURY OCCURED and Number or Rui	AMILABLE PRIOR TO COMPLETION OF CAL OF DEATH?  1 YES 2 YHO  ral Route Number,				
BE COMPLETED BY PHYSICIAN: MEDICAL	PART II. Other algnificant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined  290. CERTIFIER (Check only One)  2 MEDICAL EXAMIN	NOSPITAL:  1 Nopelent 2 = ER/Out  28e. DATE OF INJURY (Month, Day, Vear)  28e. PLACE OF INJURY building, stc. (Sp.  SICIAN: To the best of my knovier:  On the besis of examinations.	ripatient 3 DOA 20b. Time INJU  RY — At home, ferm, streedly)  wiedge, death occurred ion and/or investigation  DEATH (ITEM 27) (Type, I	28. PLACE OF DEATH OTHER: 4   Nursing Home 5   Resident OF WORK? AND WORK? 1   YES 2   NO Irrest, factory, office  d at the time, date and place, and on, in my opinion, death occurred at  29c. LICENSE	(Check only one)  Ce 6 Other (Specify)  28d. DESCRIBE HOW  28f. LOCATION (Street City or Town, State due to the cause(s) and muthe time, data and place, a NUMBER	INJURY OCCURED  and Number or Rui  anner as stated. ind due to the caus  29d, DATE SIGN	1 VES 2 TANO  Tel Route Number,  se(a) end manner ee stat  SED (Month, Day, Year)				

BALTIMORE, MARYLAND 21215-0020

SION OF VITAL RECORDS, P.O. BOX 68760,



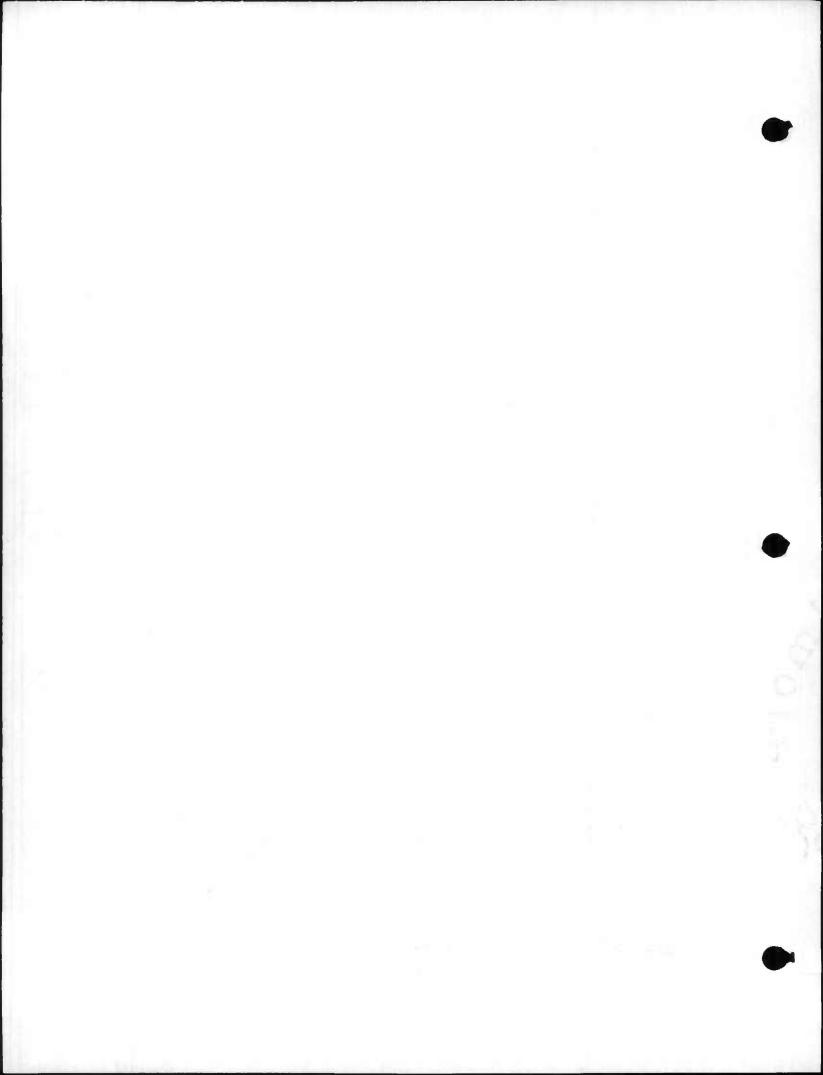
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		Pages
		and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
020	executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	burial-trans
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	BALTIMORE, MARYLAND 21215.	death. Page 6 may be retained by the hospital or attendi	e funeral director, page 5 should be detached for use as it.	examiner must be notified at once.
(	DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR AT WHEN THE TWO FOR IT THE TAW REQUIRES THAT THE DESCRIPTION THE HOSPITAL OR AT NOTING A NOTION OF THE MOSPITAL OR AT NOTION OF THE MOSPITAL O	TO THE FUNERAL DIRECTOR Securificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARY	LAND / DEPAR CERTIFI	TMENT OF I	HEALTH AND	MENT	AL HYGIEN	E	) (	77040	,
	1. OECEOENT'S NAME (First, Middle, Last)	1.2.2.	-10				E OF OEATH			3. TIME OF DEAT	н
1	JOHN W.	WALTH	EK			3	30	) 0	73	0040	14 M
- 3	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	F UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE	E OF BIRTH oth, Day, Year)		a. BIRTH Countr	IPLACE (State or Fo	reign
	579-05-0300  9a. FACILITY NAME (If not institution, give	M 2 F	90 YRS.		OR LOCATION OF C	12	-21-0	3 Pc. COUN	Wash	ington,	D.C.
DIRECTOR	Suburban Hospit			Bethe		AAIII			tgom		
3EC	10a. STATE 10b. COUNT	TY	10c. CITY	, TOWN OR LOCA	TION					10d. INSIDE CITY	
	Maryland Mon	tgomery	Bet	hesda						LIMITS?	NO
FUNERAL	10e. STREET AND NUMBER			10	1. ZIP CODE			10g. CITIZ	ZEN OF V	VHAT COUNTRY?	
Ä	6017 Walhonding				20816			U.	S.A.		
5	11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEDENT EVER	IN U.S. ARMED	13. WAS DEG	ENDENT OF HISPA	NIC ORIG	IN? (Specify Yes Rican, etc.)	or No-	14. RACE Black	— American India	n,
ВУ	3 📉 Widowed 4 🗌 Divorced	IF YES, GIVE WAR OR D	DATES	1 TYES	XX NO Spec	lfy:			Speci		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	JCATION	16a, OECEDENT'S	USUAL OCCUPATI	ON	18	b. KIND OF BUS	INESS/IND		HITE	
	Elementery/Secondary (0-12)	College (1-4 or 5 +)	(Give kind of w life. Do NOT use	ork done during me retired.)	est of working						
MP	12		Electri	cian			U.S. Go	v't.			
8	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S N						
B	Charles H.M. Wal	ther					ronia I				
2	19a. INFORMANT'S NAME (Type/Print)	7			and Number or Rural						
	John W. Walther			Fallsme.		7	ville,				
	1 Burial 25 Cremation 3 Rem 4 Donation 6 Other (Specify)		b. PLACEAND DATEO metery, cremetory or off ETTOPOLIT			0A		CATION — C		wn, State Virgini	
	21, SIGNATURE OF FUNERAL SERVICE LI		ecroporic	22, NAME A	NO ADDRESS OF F	ACILITY	-1	Xand	LIA,	ATISTII	.a
	Sarry Je	7.7		Lees	burg, In	c. 2	01 Edwa	rds	erai Ferr	Home of y Rd., N	V.E.
	23. PART I. Enter the disesses, or		d the death. Do n	ot enter the me	de of dulos au	L	eesburg	, VA	220	75	
	snock, or neart tellure.	List only one cause on a	ech Ilne.	or ontor the me	de or dying, ad-	JII 44 (4)	diac or reopi	atory sire	rat,	Approxima Interval Be	tween
	IMMEDIATE CAUSE (Final disease or condition resulting in death)								Death		
	e									$\dashv$	
z	Sequentially list conditions b.										
틸	Sequentlelly list conditions, If any, leading to immediate										
2	CAUSE (Disease or Injury  CHISTORY DUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	that initiated events resulting in death) LAST	DOE TO (OR AS	A CONSEQUENCE OF	):							
		d	155							1	
¥	PART ii. Other aignificent condition	ne contributing to death t	out not reaulting in	the underlyin	g cause given in	Part i.	24a. WAS AN		24b.	WERE AUTOPSY FIN	
ă							1 YES 2	X NO		COMPLETION OF CA	
×							-			1 NES 2 N	•
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL			-							
딣	EXAMINER?	HOSPITAL:		OTHER:	ACE OF OEATH (C						
Ĭ	27. MANNER OF DEATH	1 Inpetient 2 FER/Out 28a. DATE OF INJURY	28b. TIME		e 5 🗆 Residence		er (Specify) SCRIBE HOW IN	LILIBY OCC	UPED		
	1 Natural 5 Pending	(Month, Day, Year)	INJU	JRY WO	PK? YES 2 NO				ONED		
BY	3 Suicide 8 Could not be	2 Accident  3 Suicide 26a. PLACE OF INJURY — At home, farm, street, factory, office 28t, LOCATION (Street and Number or Bural Boute Number						-			
COMPLETED	4 Homicide determined	building, atc. (Spe	GIIY)			City	or Town, State)				
٦ I	29a. CERTIFIER Check only	ICIAN: To the best of my know	rledge, death occurred	d at the time, data	and place, and du	to the ca	use(a) and men	ner aa atate	ıd,		
ŏ.		ER: On the beals of examination								and manner as str	ited.
w II	296. SIGNATURE AND TITLE OF CERTIFIE	R			29c, LICENSE NU	MBER		29d. DATE	SIGNEO	(Month, Day, Year)	-
m	2065	25		~	40	8 -	544	•	3	-30-	92
임	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	EATH (ITEM 27) (Type,	Print)	0		9	504	- 20	solo o	M
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,  10 THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after of TO THE FUNERAL DIRECTIOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical or	BALTIMORE, MARYLAND 2121	iours after death. Page 6 may be retained by the hospital or atte	d in by the funeral director, page 5 should be detached for use or removal.	medical examiner must be notifled at once.
E SE	DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cardificate be executed within 24 hours after death. Page 6 may be retained by the hospital or atte	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use be fleet within 72 hours after clearly with the State Dect of Health and Mental Hydiene prior to burial cremation, or removal	IMPORTANT: if Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM CERTIFIC	ENT OF HEALTI	H AND ME	NTAL HYGIEN REG. NO		3 09646
	1. DECEDENT'S NAME (First, Middle, Last)	Della M	Marie Yo	е		pate of Death Month pril 5,	* 1993 <sup>E</sup>	3. TIME OF DEATH 10:33 a. M
	4. SOCIAL SECURITY NUMBER 223-12-6713	1 🗌 M 2 🖔 F		UNDER 1 YEAR IF UND WITHS DAYS HOURS	BIR 24 HRS. 7.	DATE OF BIRTH (Month, Day, Year) Dr. 17	8.8	NATHPLACE (State or Foreign Country)  Virginia
TOR	9a. FACILITY NAME (if not institution, give str 3612 Hamilton	· · · · · · · · · · · · · · · · · · ·	96	CITY, TOWN OR LOCAL Balti	imore C		9c. COUNTY	
DIRECTOR	100. STATE 10b. COUNTY Maryland				Baltimore City			10d. INSIDE CITY LIMITS? 1 X YES 2 NO
FUNERAL	10%. STREET AND NUMBER 3612 Hamilton	Avenue		101. ZIP CO	7	1214		of WHAT COUNTRY? ted States
ВУ	11. MARITAL STATUS 1  Never Married 2 Married 3  Widowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DATE	2 X NO	13. WAS DECENDENT If you, specify Cul 1  YES 2 X NO	oen, Mexican, Pu	PRIGIN? (Specify Yes verto Rican, etc.)	- 1	RACE — American Indian, Black, White, etc. Specify: White
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	ATION tompleted)  College (1-4 or 5+)	6a. DECEDENT'S USL (Give kind of work life. Do NOT use re Homemake	done during most of worldired.)	king	16b. KIND OF BU	SINESS/INDUST	RY
BE CON		lensley			Α	First, Middle, Meiden 1cy Wes	t	
5	19a. INFORMANT'S NAME (Type/Print) HOWard P. Yoe 20a. METHOD OF DISPOSITION	- Law-	3612			Baltimo	re, Man	ryland 21214
1	1 X Buriel 2 Cremation 3 Remo 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice	val from State comete				Ti		Maryland
	> nulton	1. Knight	inight Jr	Leonard (	. Ruck	, Inc. 5	305 Har	Md. 21214 rford Road
CERTIFICATION	iMMEDIATE CAUSE (Finel disease or condition resulting in death)  Sequentiely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A C	ONSEQUENCE OF):  ONSEQUENCE OF):  ONSEQUENCE OF):	Joes	eki.	l ci (		interval Retween
N: MEDICAL	PART II. Other significent conditions	le underlying ceuse		1 YES 2	MED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO		
SICIAN		HOSPITAL: 1   Inpatient 2   ER/Outpati		26. PLACE OF THER:	DEATH (Check of			
ву РНҮ	27. MANNER OF DEATH  1 Netural 5 Pending Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF			1. DESCRIBE HOW I	NJURY OCCURE	D
0	2 Accident Investigation 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify)  28e. PLACE OF INJURY — At home, farm, street, factory, office City or Yown, State)					ural Route Number,		
COMPLET		IAN: To the best of my knowled : On the basis of axamination a						use(s) and manner as stated.
TO BE C	296. SIGNATURE/AND SITLE OF CENTIFIER	mor		Do	CENSE NUMBER	8.	29d. DATE \$10	SNED (Month, Day, Year)
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	APR 06 1993	232. ARTHUSTHAR'S SHOW	de 10					



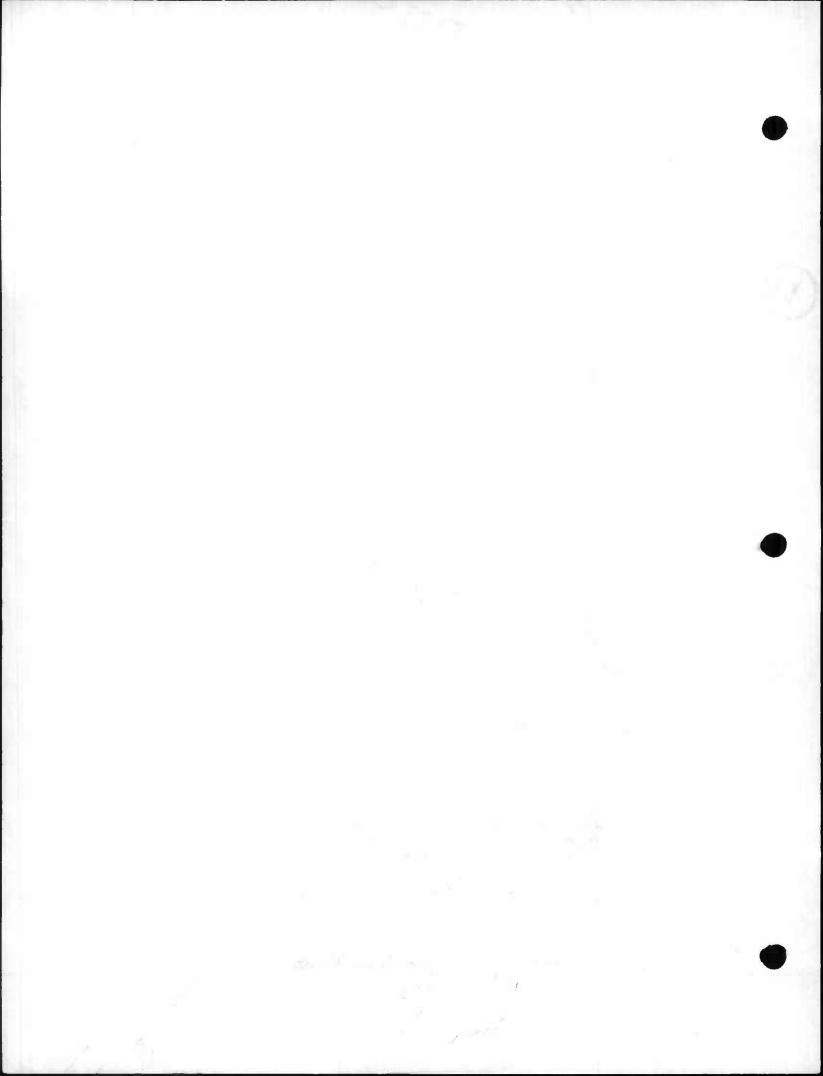
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TAL RECORDS, P.O. BOX 68760,	The law requires that the death certificate he executed within 22
/ITAL RECORDS, P.O. BOX 68760,	III. The last requires that the death certificate he securited within "I have after death. Done & over he certified by the housing or establish or established by the housing

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	1 - STATE REGISTRAR		CERTIFIC	CATE OF	DEATH	REG. NO		33 09	
1 3	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH D	AY YI	3. TIME OF DE	
	Virgin  4. SOCIAL SECURITY NUMBER	<u>ia Madeline</u>				04/02/			
	215 16 6656	1 - M 2 M 5		IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Country)	
	9e. FACILITY NAME (If not institution, give	X 1 69		DE CITY TOWN	OR LOCATION OF D	03/30/19	924	Marylan	
H.		cott Key Me			timore	LAIN	SC. COUNTY	OF DEATH	
CTOR	RESIDENCE OF DECEDENT								
DIRE	10a. STATE 10b. COUNT	TY	10c. CITY,	, TOWN OR LOCA	TION			10d. INSIDE CI LIMITS?	
	Maryland  10e. STREET AND NUMBER		B	Baltim	ore			TYPES 2	
FUNERAL		Tamfamali				0.0		OF WHAT COUNTRY	
JNE	11. MARITAL STATUS	Layfayett 12. WAS DECEDENT EVER IN		13 WAS DE	212	U Z NIC ORIGIN? (Specify Ye		J.S.A.	
	1 Never Married 2 X Married	FORCES? 1 YES	2.A. MO	If yes, s		en, Puerto Rican, etc.)	I GI NO	Stack, White, etc.	
84	3 Widowed 4 Divorced	in the distriction on		1012	a MV Vuo abeca	ry.		Specify: Wh	
LED	15. DECEDENT'S EDI (Specify only highest grad	JCATION le completed)	16a. DECEDENT'S U	ork done during m		16b. KIND OF BU	SINESS/INDUS	ТНҮ	
LET	Elementary/Secondary (0-12)	College (1-4 or 5 +)	iffe. Do NOT use	retired.)					
COMPL	1.2 17. FATHER'S NAME (First, Middle, Last)		H	Iomema					
_	James 1	Moore				AME (First, Middle, Meiden	Sumame)		
8E	19a. INFORMANT'S NAME (Type/Print)	10016	19h MAILING	ADDRESS /Street		tta Wolf	m State 7in Co.	of a l	
2	III 19s INFORMANT'S NAME (Tros/Print)								
	20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State								
	1Kl Burlel 2 Oremation 3 Removel from State    4   Donation 8   Other (Specify)								
- A	21. SIGNATURE OF FUNERAL SERVICE L		,	22. NAME /	ND ADDRESS OF F	ACILITY			
	hum 19	Donas				nss Funei			
	23. PART I. Enter the diseases, or	complications that caused	the death. Do no	ot enter the m	ode of dving, suc	s Road, I	ratory arrest	Md 212 Approxi	
	IMMEDIATE CAUSE (Fine)		0.0000000000000000000000000000000000000			Interval Onset a			
	disease or condition	AR	0					0.1351 4	
	resulting in death)	DUE TO (OR AS A	CONSEQUENCE OF)	):				1	
_	and the same of the same of	· Sex	515						
= 1	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS'A	CONSEQUENCE OF)	):	MI				
TIO				-				1	
CATIO	cause, Enter UNDERLYING CAUSE (Disease or Injury	c Hun-	Y CUY	we		-			
TIFICATION	cause, Enter UNDERLYING	C. DUE TO (OR AS A	CONSEQUENCE OF)	TUC	1 1	50			
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	d							
	cause, Enter UNDERLYING CAUSE (Disease or Injury that initiated events	d			ng cause given in	Part I. 24s. WAS AN		24b. WERE AUTOPSY	
	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	d			ng cause given in	Part I. 24s. WAS AN PERFOI	RMED?	AMILABLE PRIO COMPLETION OF	
	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	d			ng cause given in	PEHFOI	RMED?	AMAILABLE PRIO	
: MEDICAL	cause, Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other aignificant condition	d			ng cause given in	PEHFOI	RMED?	AMILABLE PRIO COMPLETION OF OF DEATH?	
AN: MEDICAL	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	d,ns contributing to deeth bu	it not resulting in	n the underlying	ng cause given in	1 TYES 2	RMED?	AMILABLE PRIO COMPLETION OF OF DEATH?	
SICIAN: MEDICAL	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other algnificant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 NO	HOSPITAL:	it not resulting in	28. F OTHER:	LACE OF DEATH (C/	1 TYES 2	RMED?	AMILABLE PRIO COMPLETION OF OF DEATH?	
PHYSICIAN: MEDICAL	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other aignificant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 VES 2 NO  27. MANNER OF DEATH	dns contributing to deeth bu	it not resulting in	26. F OTHER: 4   Nursing Hoto	PLACE OF DEATH (C/	1 VES 2	AMEO?	AMALABLE PRIO COMPLETION OF DEATH?  1  YES 2	
PHYSICIAN: MEDICAL	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other aignificant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 VES 2 NO  27. MANNER OF DEATH  1 Vistural 5 Pending Investigation	HOSPITAL: J-Timpatient 2 ER/Outpry  28e. DATE OF INJURY (Month, Day, Year)	it not resulting in	26. F OF Zec. IN OF W M 1	PLACE OF DEATH (C/	neck only one)  6 Other (Specify)  28d. DESCRIBE HOW I	NJURY OCCUR	AMALABLE PRIO COMPLETION OF DEATH?  1  YES 2   ED	
ED BY PHYSICIAN: MEDICAL	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other algnificant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending	HOSPITAL: Jacob Date OF INJURY (Month, Day, Year)	it not resulting in	26. F OF Zec. IN OF W M 1	PLACE OF DEATH (C/	1   YES 2	NJURY OCCUR	AMALABLE PRIO COMPLETION OF DEATH?  1  YES 2   ED	
ETED BY PHYSICIAN: MEDICAL	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reaulting in death) LAST  PART II. Other aignificant conditio  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	HOSPITAL:  JET Inpetient 2 = ER/Outpe  28e. DATE OF INJURY (Month, Day, Year)  28e. PLACE OF INJURY building, etc. (Specif	it not resulting in	26. F OTHER: 4   Nursing Hoi OF   28c. IV IT   1   1   1   It rest, factory, offi	PLACE OF DEATH (C/	neck only one)  6 Other (Specify)  28d. DESCRIBE HOW I  28f. LOCATION (Street City or Town, State)	NJURY OCCUR	AMALABLE PRIO COMPLETION OF DEATH?  1  YES 2   ED	
ETED BY PHYSICIAN	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reaulting in death) LAST  PART II. Other aignificant conditio  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be delermined  29a. CERTIFIER (Check only 1 CERTIFYING PHYS	HOSPLTAL: J-Tinpetient 2 - ER/Outpe  28e. DATE OF INJURY (Month, Day, Year)  28e. PLACE OF INJURY building, etc. (Special Content of the best of my knowled)	at not resulting in	26. F OTHER: 4   Nursing Hot OF M 1   Irrest, factory, offi	PLACE OF DEATH (C/	neck only one)  6 Other (Specify)  28d. DESCRIBE HOW I  28f. LOCATION (Street City or Town, State)	NJURY OCCUR	AMALABLE PRIO COMPLETION OF DEATH?  1  YES 2   ED	
ED BY PHYSICIAN: MEDICAL	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other aignificant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO  27. MANNER OF DEATH 1 Tetural 5 Pending Investigation 2 Accident 3 Suicide 6 Could not be delermined  29a. CERTIFIER (Check only one) 2 MEDICAL EXAMIN	HOSPITAL:  JET Impetient 2 ER/Outps  28e. DATE OF INJURY (Month, Day, Year)  28e. PLACE OF INJURY building, etc. (Special Section 1) and the property of the post of my knowle ER: On the best of examination	at not resulting in	26. F OTHER: 4   Nursing Hot OF M 1   Irrest, factory, offi	PLACE OF DEATH (C/me 8	1   YES 2  Teck only one)  6   Other (Specify)  28d. DESCRIBE HOW I  28f. LOCATION (Street City or Town, State)  to the cause(e) and many time, date and place, er	NJURY OCCUR	AMALABLE PRIO COMPLETION OF DEATH?  1  YES 2   ED  Flural Route Number,	
ETED BY PHYSICIAN: MEDICAL	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reaulting in death) LAST  PART II. Other aignificant conditio  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be delermined  29a. CERTIFIER (Check only 1 CERTIFYING PHYS	HOSPITAL:  JET Impetient 2 ER/Outps  28e. DATE OF INJURY (Month, Day, Year)  28e. PLACE OF INJURY building, etc. (Special Section 1) and the property of the post of my knowle ER: On the best of examination	at not resulting in	26. F OTHER: 4   Nursing Hot OF M 1   Irrest, factory, offi	PLACE OF DEATH (C/me 8	1   YES 2  Teck only one)  6   Other (Specify)  28d. DESCRIBE HOW I  28f. LOCATION (Street City or Town, State)  to the cause(e) and many time, date and place, er	NJURY OCCUR	AMALABLE PRIO COMPLETION OF DEATH?  1  YES 2   ED	

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(ITEM 27) (Type, Print)



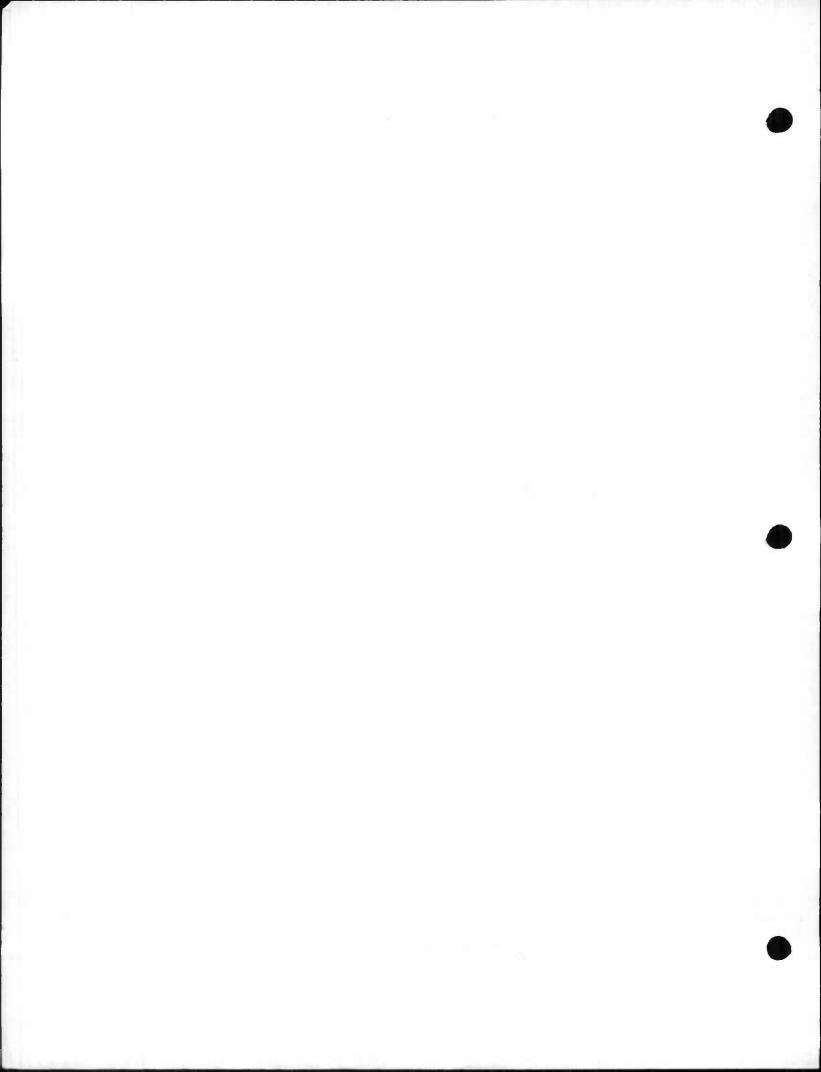
VIVISION OF VITAL RECORDS, P.O. BOX 68760,	
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MCRPTAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. PORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYLAND		MENT OF H		MENTAL HYGIE	IVE	3 09648
	1. DECEDENT'S NAME (First, Middle, Last)				**	2. DATE OF DEATH	70	3. TIME OF DEATH
	Alan A. And	lerson, Jr.	NI NI			MONTH 3	6 9	3 0730 a <sub>M</sub>
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (in yrs.		F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign
	225-22-0762	1 X M 2 □ F 82	YRS.	ONTHS DAYS	HOURS MIN.	02 08	11	Washington DC
_	9e. FACILITY NAME (If not institution, give a	street end number)	1	b. CITY, TOWN O	R LOCATION OF D	EATH		Y OF DEATH
FUNERAL DIRECTOR	Bedford Court			Silver	Spring		Mont	gomery
딦	RESIDENCE OF DECEDENT  10e. STATE 10b. COUNT	Y	10c. CITY	TOWN OR LOCAT	ION			10d. INSIDE CITY
E	Maryland Monte	gomery		er Spri				LIMITS?
7	10e. STREET AND NUMBER	, o mo L y	DIIV		ZIP CODE		10g, CITIZE	EN OF WHAT COUNTRY?
8	15100 Interlocher	Drive #108			20906		USA	
5	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S.	ARMED	13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Specify		4. RACE — American Indian.
BY F	1 Never Married 2 X Merried 3 Widowed 4 Divorced	FORCES? 1 TYES 2 FIF YES, OIVE WAR OR DATES	Z) NO	If yes, spe		y:		Black, White, etc. Specify:
				1				Black
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION 16e.	(Give kind of wor	K done during mos	N st of working	16b. KIND OF	USINESS/INDU	STRY
٦	Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT use	1000	M	110 0		
× ×	12 17. FATHER'S NAME (First, Middle, Last)	5+Ini	cormati	on Syst	ems Man		ernmen	T.
	Alan A. Anderson	C so				ME (First, Middle, Maid te Hill	en Surname)	
BE	19e. INFORMANT'S NAME (Type/Print)	Sr.	105 MARINO A	DDBECG (Stand or	0	Route Number, City or 1		
2	Lucille S. Anders					Silver St		
	20a, METHOD OF DISPOSITION	20h.PLA0		DISPOSITION (Nat				ty or Town. State
	1 ☑ Burlet 2 ☐ Cremetion 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	ioval from State cemetery	cremetory or other	r nlacal		1		oring, Maryland
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	OI HE	22. NAME AN	D ADDRESS OF FA	CLZ/93LS1	iver Si	ring, Maryland
	Daywig ()	Pot		Hines-	Rinaldi	Funeral I	lome	
	23. PART I. Enter the disease, or	complications that caused the	death Do not	1118UU	New Hami	shire Ave	, SILV	er Spring, MD
	anock, or neart fellure.	Liet only one ceuse on each if	ine.	the the	a or crying, suc	in all certified or re-	phretory arres	Intarval Between
	IMMEDIATE CAUSE (Final disease or condition	. ANEUMON	11A					Onaat and Death
H	resulting in death)	DUE TO (OR AS A CONS						
z	The state of the s	h						
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONS	SEOUENCE OF):					
2	CAUSE (Disease or Injury	c						
E	that initiated events resulting in death) LAST	DUE TO (OR AS A CONS	SEOUENCE OF):					
<b>H</b>		d						
AL	PART II. Other algnificant condition	is contributing to death but no	t reculting in	the underlying	cause given in	Pert I. 24s. WAS	AN AUTOPSY	24b. WERE AUTOPSY FINDINGS
5	MALIGNANT	CYMPHOMA				PERF	ORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
Ä	PROSTATIC	CARCINOMA						OF DEATH?
ä								
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				ACE OF DEATH (Ch	eck only one)		
Š	1 TES 2 NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 DOA 4	THER:  A Nursing Home	5 - Reeldence	6 Other (Specify)		
H	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME (	OF 28c. INJL		28d. DESCRIBE HOV	INJURY OCCU	RED
B⊀	1 Netural 5 Pending 2 Accident Investigation				ES 2 NO			
	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At building, atc. (Specify)	home, farm, stre	et, factory, office		26t. LOCATION (Street City or Town, Sta	t end Number or	Rural Route Number,
E								
COMPLETED		ICIAN: To the best of my knowledge,						
Š	2 MEDICAL EXAMINE	R: On the beels of examination and/	or investigation,	in my opinion, de	ath occured at the	time, date and place,	end due to the	cause(e) end manner ee stated.
BE C	29b. SIGNATURE AND TITLE OF CERTIFIE	R			29c. LICENSE NUI	MBER	29d. DATE S	SIGNED (Month, Day, Year)
10	JEDRILLE	M			633	700	1 3	-17-93
-	30. NAME AND ADDRESS OF PERSON WH		TEM 27) (Type, Pr	•		44.45	11.0	
		OWE		04	NEY.	MARYCA	+WD	20832
	MAR 23 '93	32. REGISTRAN'S SIGNATURE	Randall					

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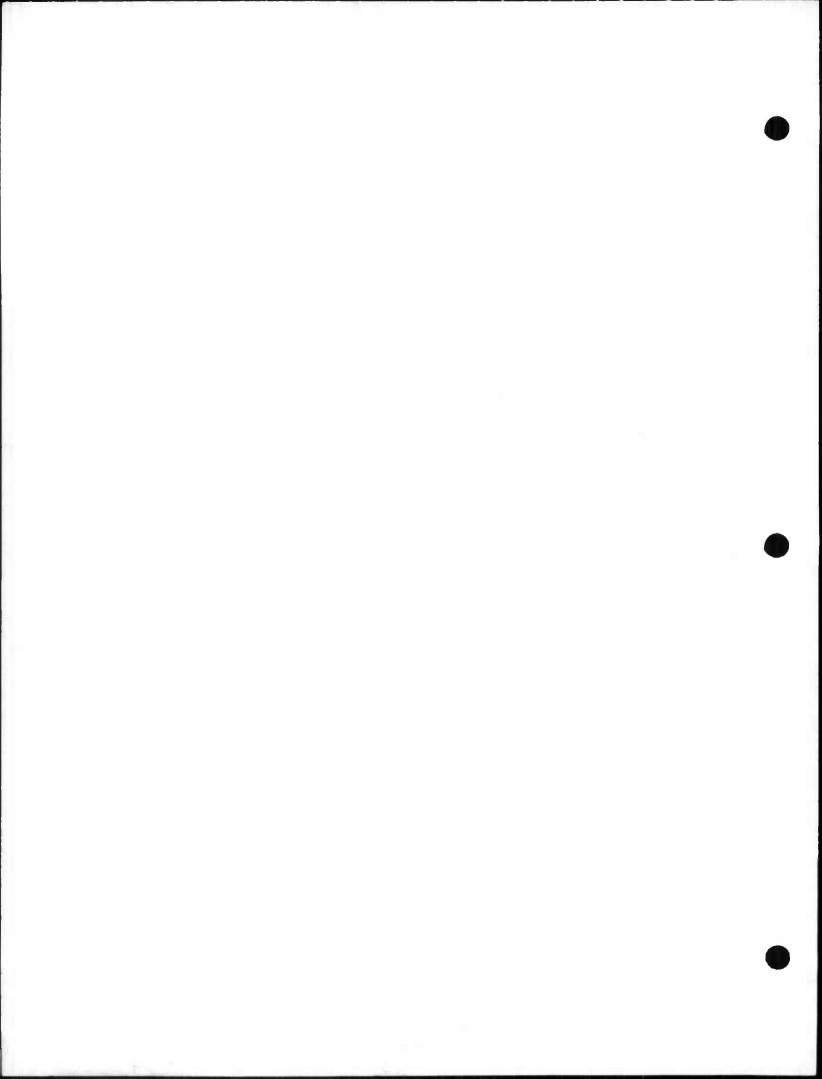
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THE HOS INLIES AND TRENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TOTHE HOWERLA DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be attended to use as the burial-transit permit. Pages 1, 2, 3 should be attended to use as the burial-transit permit. Pages 1, 2, 3 should be attended to use as the burial-transit permit. Pages 1, 2, 3 should be attended to use as the burial-transit permit. Pages 1, 2, 3 should be attended at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI	MENT OF H	EALTH AND	MENTAL HYGIEN		, 0,01,5	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH	
	Aspasia Serk	edakis	Asvestas			March 9	, 1993 <sup>re</sup>	10:45 P M	
	4. SOCIAL SECURITY NUMBER		The second second	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. 6	BIRTHPLACE (State or Foreign Country)	
	579-01-0658		81 YRS.	DAYS	HOURS MIN.	Dec. 27,	1911	Greece	
~	9e. FACILITY NAME (If not institution, give str			b. CITY, TOWN O	R LOCATION OF D	EATH	9c. COUNTY	OF DEATH	
DIRECTOR	Springbrook Adv	entist Nursi	ng Home	Silver	Spring		Mont	gomery	
EC	10e. STATE 10b. COUNTY		10c. CITY, 1	TOWN OR LOCAT	ION			10d. INSIDE CITY	
	MD Mo:	ntgomery	Sil.	ver Spr	ing			LIMITS?	
AL	10e. STREET AND NUMBER				ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?	
FUNERAL	712 Langley Plac	e			20901		US	SA	
E	11. MARITAL STATUS  1 Never Merried 2 Merried	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DECE	ENDENT OF HISPAI	NIC ORIGIN? (Specify Yes	or No 14.	RACE — American Indian, Black, White, etc.	
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	ATES		2 X NO Specif			Specific:	
	15. DECEDENT'S EDUC	ATION	16a. DECEDENT'S US	UAL OCCUPATIO	M	16b. KIND OF BU	OUNCES (INIDATES	White	
ET	(Specify only highest grade of Elementary/Secondary (0-12)	Completed) College (1-4 or 5 +)		done during mos		IGO. KIND OF BU	SIME 22/INDO21	HY	
AP		1	Clerica	1		Federa	l Gov't		
COMPLETED	17, FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden			
BE (	Constantine Geor	ge Serkedaki	S		Helen	Economou			
6	19a. INFORMANT'S NAME (Type/Print)		1			Route Number, City or Tow			
	Angelo Asvestas					lver Spring	g, MD	20901	
	20e. METHOD OF DISPOSITION  1 Description   1 Description   2 Description   3	val from State 20b.	PLACE AND DATE OF D glery, cremetory or other	DISPOSITION (Ner	ne of	OATE 20c. LO	CATION — City	or Town, Slate	
	4 Donation 5 Other (Specify)	FNSFF	ate of He	aven Ce	emetery	3/13 Sil	ver Sp	ring. MD	
	N . 1	dn		Joseph	abbhess of fa Gawler	's Sons, I	nc.		
	muchael	-c-/hul	don	5130 V	Visconsi	n Ave. NW. W	aching	ton.DC 20016	
	22 PART I. Enter the diseases, or co shock, or heert fellure. L	implications that caused list only one cause on e	tha death. Do not sch line.	enter the mod	la of dying, suc	h as cerdiac or respi	ratory arrest,	Approximata Interval Between	
	IMMEDIATE CAUSE (Finel disease or condition			- 1(				Onset and Death	
	resulting in death)	CHA. C	ामुह्युश्य व व	e Hea	HET TA	HEUNE		6 MTHS	
-	disease or condition resulting in death)  a. CHY. CONCESTIVE HEART FAILURE  OUE TO (OR AS A CONSEQUENCE OF):								
ě	Sequentially list conditions, if any, leading to immediate  DUE TO (OR AS A CONSEQUENCE OF):								
S	cause. Enter UNDERLYING CAUSE (Disease or Injury CAUSE (Disease or Injury								
E	that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):						
CERTIFICATION	d.	•							
AL C	PART II. Other significant conditions	contributing to daeth be	ut not resulting in t	ha underlying	cause given in	Part I. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS	
2	CHRONIC OF					000000	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
	CHEONIC AN	EMIA- MOI	O-ARECITI	C		T VES 2	ER NO	OF DEATH?	
ž						_		T TES 2 NO	
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	11000171			ACE OF DEATH (Ch	eck only one)			
YSI	1 TYES 2 X NO	HOSPITAL: 1   Inpatient 2   ER/Oulpi	etlent 3 DOA 42	THER:  Nursing Home	5 - Residence	6 Other (Specify)			
H	27. MANNER OF OEATH  1 💢 Natural 5 🗌 Pending	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME O	F 28c, INJU WOF		28d. OESCRIBE HOW II	NJURY OCCURE	0	
BY	2 Accident Investigation				ES 2 NO				
	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, stc. (Speci	— Al home, farm, streety)	et, factory, office		28f. LOCATION (Street a City or Town, State)	nd Number or Ru	ural Route Number,	
COMPLETED	290. CERTIFIER X CERTIFYING PHYSIC						<u> </u>		
M	(Check only CERTIFYING PHYSIC	IAN: To the best of my knowle	edge, death occurred a	t the time, date a	and piece, and due	to the cause(s) end man	ner ee stated.		
8		On the basis of exemination	end/or investigation, is	n my opinion, de	ath occured at the	lime, date end place, and	d due to the ceu	use(e) end menner ee stated,	
BE	296. SIGNATURE AND TITLE OF CENTIFIER	1. 1.100			29c. LICENSE NUN		29d. DATE SIG	ned (Month, Day, Year) r. 10, 1993	
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE DE DE	TH (ITEM OR CITE OF	od)	D059	0 (	P IId	2. 10, 1995	
	John P. Nassou,	M.D., 10620	Georgia A	ve., S	ilver Sp	ring, MD	20910		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA	TURE						
	MAR 22 '93	Gulia Davi	Gon-Randell	la ,					



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YSICIAN: The law requires that the death certificate be executed v	certificate has been signed to the State Deer of Health	200
SICIAN:	prtifica to St	200
HYSI	his ce	1 111111
ING P	Affer 1	COROL
E HOSPITAL OR ATTENDING PHYSI	UNERAL DIRECTOR: After this cer within 72 hours after death with the	10117
OR AT	DIRECTOR: J	200
TAL	UNERAL DIR	
HOSE HOSE	FUNE	
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and .	196.3	

93 09650 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REGISTRAR	TE OF MARYLAND	ERTIFIC			IENTAL HYGIEN	E 93	09650					
	1. DECEDENT'S NAME (First, Middle, Last) HILDA BAL	AKIRSKY	4			2. DATE OF DEATH DA	92	3. TIME OF DEATH					
	058-07-1957	6. AGE (In yrs. le	YRS. MO	UNDER 1 YEAR		7. DATE OF BIRTH (Month, Day, Year) May 15, 19	Co	ATHPLACE (State or Foreign unitry)					
TOR	9a. FACILITY NAME (If not institution, give street and Hebrew Home of Greate RESIDENCE OF DECEDENT	Hebrew Home of Greater Washington Rockville Montgomery											
DIRECTOR	Maryland Montgome		10c. CITY, TO	CKVILL				10d. INSIDE CITY LIMITS?  1 X YES 2 NO					
FUNERAL	100. STREET AND NUMBER 6105 Montrose Road 11. MARITAL STATUS				20852		United	States					
BY	1 Never Married 2 Married FO	AS DECEDENT EVER IN U.S. AI RCES? 1 TYES 2 TYES YES, GIVE WAR OR DATES	RMED NO	If yes, spe	ENDENT OF HISPANI city Cuban, Maxican 2 NO Specify:	C ORIGIN? (Specify Yea , Puerto Rican, etc.)	8	ACE — American Indien, leck, White, etc. pecity: White					
COMPLETED		od) (0	ECEDENT'S USU Give kind of work e. Do NOT use red	done during mos		16b. KIND OF BUS	INESS/INDUSTRY						
COMP	11 17. FATHER'S NAME (First, Middle, Last)		<u>Salespe</u>	rson	16. MOTHER'S NAM	Ret. E (First, Middle, Meiden S							
TO BE	Jacob Vishkoff  19e. INFORMANT'S NAME (Type/Print)				nd Number or Rural Ro	oute Number, City or Town	(Unknow	,					
	Nat Balakirsky (son) 66 Camelot Ct., Piscataway, NJ 08854  20a. METHOD OF DISPOSITION  20b. PLACEAND DATE OF DISPOSITION (Name of State Camelogy Company of other place)  20b. PLACEAND DATE OF DISPOSITION (Name of Camelogy Company of other place)												
	4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LICENSEE  AULU  TO STATE OF TUNERAL SERVICE LICENSEE	m State   cemetery, cr Monte	address of factorsky-Gold	berg Memo:	rial Ch	apels, Inc.							
CERTIFICATION	23. PART I. Exter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory strest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  PUE TO (OR AS A CONSEDUENCE OF):  DUE TO (OR AS A CONSEDUENCE OF):  DUE TO (OR AS A CONSEDUENCE OF):  DUE TO (OR AS A CONSEDUENCE OF):  OUE TO (OR AS A CONSEDUENCE OF):  OUE TO (OR AS A CONSEDUENCE OF):												
MEDICAL	PART II. Other eignificant conditions contr	Ab. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?  1 YES 2 NO											
PHYSICIAN:	1 YES 2 NO 1 In	PITAL: petiant 2 ER/Outpetient :  Ja. DATE OF INJURY (Month, Day, Year)	3 DOA 4	HER: Nursing Home			JURY OCCURED						
TED BY	2 Accident Investigation	Da. PLACE OF INJURY — At he building, atc. (Specify)	ome, term, street		ES 2 ND	261. LOCATION (Street as City or Town, State)	nd Number or Run	al Route Number,					
COMPLET		the best of my knowledge, do						e(a) and manner as stated,					
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER  MULLY VOLUME  30. NAME AND ADDRESS OF PERSON WHO COMPI	y MD. PH	HYSIC	IAN	29c, LICENSE NUME D35			EO (Month, Day, Year) 20/93					
	31. DATE FILED (MONTH), Day, Year) 32	COLUMN SIGNATURE SIGNATURE	21) (1) po, Print 261A	AVE	E, Sui	TE 22	7,51	VER SPRING					
1	MAR 22 '93	guille Davidson	CONTRACTOR										

BALTIMORE, MARYLAND 21215-0020	YSICIAN: The law requires that the death certificate be executed within a cours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	e medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HIGH OIL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 wours after death. Property of the thing of	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAN	ID / DEPAR	TMENT OF H	EALTH AND DEATH	MENTAL HYGIEI						
	1. DECEDENT'S NAME (First, Middle, Last)	Ernest Lester				2. DATE OF DEATH		3. TIME OF DEATH				
	ERNETLESTER	BANKER				-	16 9	3 2250	M			
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In y	rs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	I. BIRTHPLACE (State or Foreign	_				
	578 <b>-</b> 38-6951	1 XM 2 □ F 67	YRS.	MONTHS DAYS	HOURS MIN.	Sept. 7,	1925	Wash., D.C.				
	9a. FACILITY NAME (If not institution, give si	reet and number)		96. CITY, TOWN	OR LOCATION OF D			TY OF DEATH	_			
OR	Anne Arundel Med	ical Center		Annapo	olis		Anne	Arundel				
DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY	,	1									
E .		Arundel		Y, TOWN OR LOCAT				10d. INSIDE CITY LIMITS?				
	10e. STREET AND NUMBER	Arundel	Ga	lesville				1 X YES 2 NO				
RA	4871 Church Lane			101	ZIP CODE			EN OF WHAT COUNTRY?				
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.	0. 101110		20765		US					
F	1 Never Merried 2 Married	FORCES? 1 XYES 2	2 NO	If yes, sp	ecify Cuban, Mexic	NIC ORIGIN? (Specify Years, Puerto Rican, etc.)	ra or No- 14	4. RACE — American Indian, Black, White, alc.				
ВУ	3 X Widowed 4 Divorced	W.W. II	S	1 TYES	2 X NO Speci	fy:		Specify: White				
COMPLETED	15. DECEDENT'S EDUC	CATION 16	a. DECEDENT'S	USUAL OCCUPATION	ON	16b, KIND OF BU	ISINESS/INDIA		_			
Ē	(Specify only highest grade Elementary/Secondary (8-12)	College (1-4 or 5 +)	(Give kind of a life. Do NOT us	work done during ma	st of working			,,,,,				
APL		2	Execu	tive		011 C	ompany					
Ö	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maide			-			
BE	Stanley Truman B	arker			Elizal	heth						
D B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a	nd Number or Rural	Floute Number, City or Tox	wn, State, Zip Cr	ode)				
F	Virginia B. Guti	errez	14113	<b>Blazer</b>	La., Si	lver Sprin	g. MD	20906	В			
	20a. METHOD OF DISPOSITION 1 □XBurlel 2 □ Cremation 3 □ Ramo	20b. PL		OF DISPOSITION (Ne		DATE 20c. LC		ly or Town, State				
	4 🗋 Donetion 5 🗆 Other (Specify)	Pa	rklawn	Memoria	1 Park	3/20 Ro	ckvill.	e, MD				
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE A			D ADDRESS OF FA	r's Sons,			$\neg$			
	Michael	& hels.						gton,DC 20016				
	23. PART I. Enter the diseases, or c	omplications that caused th	e death. Do r	ot anter the mo	de of dying, suc	ch as cardiac or resp	iratory arres	at, Approximate	-			
	iMMEDIATE CAUSE (Final	List only one cause on each	line.					interval Between				
	disease or condition resulting in death) a C U A											
- 1	DUE TO (OR AS A CONSEQUENCE OF):											
Z	Sequentially list conditions,											
Ĕ	If any, leading to immediate											
2	CAUSE (Disease or injury											
Ē	that initiated events resulting in death) LAST	DUE TO (OR AS A CO	NSEQUENCE OF	7):								
CERTIFICATION	d											
	PART ii. Other significant conditions	contributing to death but r	not reaulting i	n the underlying	cause given in			24b. WERE AUTOPSY FINDINGS	s			
PHYSICIAN: MEDICAL						PERFO		AVAILABLE PRIOR TO COMPLETION OF CAUSE				
W								OF DEATH?				
ż												
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			ACE OF DEATH (Ch	eck only one)			$\exists$			
YSI	1 YES 2 NO	100 Inpatient 2 - ER/Outpatier	nt 3 🗆 DOA	OTHER: 4  Nursing Home	5 🗆 Residence	6 Other (Specify)			1			
	27. MANNER OF DEATH  1 Natural 5 Pending	(Month, Day, Year)	28b. TIMI	URY WO	JRY AT RK?	28d. DESCRIBE HOW	NJURY OCCUP	RED				
B⊀	2 Accident Investigation				ES 2 NO							
ED	3 Suicide a Could not be 4 Homicide determined	28e. PLACE OF INJURY — A building, atc. (Specify)	At home, farm, a	treet, factory, office		281. LOCATION (Street City or Town, State	and Number or i	Rural Route Number,	٦			
COMPLETED	no. Appripip											
P P		CIAN: To the beal of my knowledge										
Ö I	2 MEDICAL EXAMINER	: On the basis of examination and	d/or investigation	n, in my opinion, de	with occured at the	time, date and place, ar	id due to the c	:ause(a) end menner as stated.	-			
BE (	296. SIGNATURE AND TITLE OF CENTIFIER	1			29c. LICENSE NUI	WBER	29d. DATE S	IGNED (Month, Day, Year)	٦			
2	Mas I mann	1 111 -			De 8	1/8	▶ 3/	17/53				
-	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH	(ITEM 27) (Type,	Print)	1, 1, -		9.	OO BESTERTER	20			
		MARK TIETIER	K	STAM	DA VE	TKINS m.	0 /	OYIZam NNA				
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATUR							コ			
ا	MAK 22 '93	Lulia Davidson	frandell.									

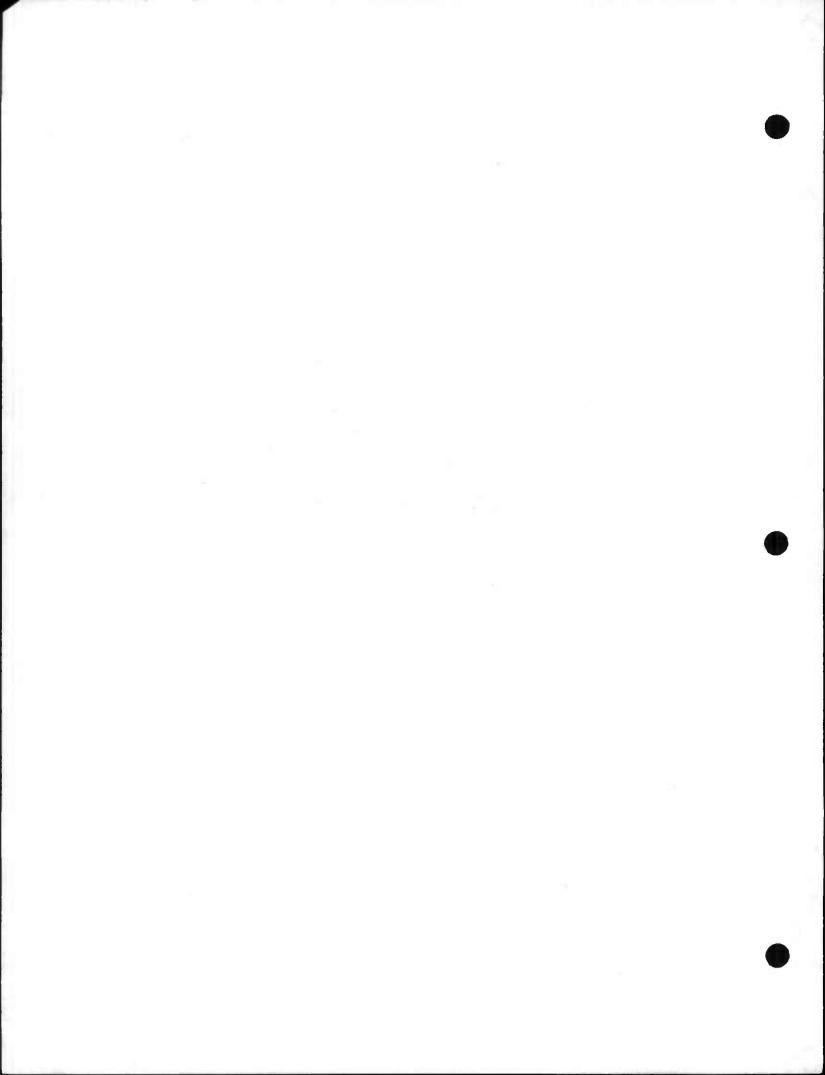
Add Vikil nekyona

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		TIEGIOTTE				CERTII	ICA	IE OI	r DEA	<u> </u>		REG. NO	•		
)		1. DECEDENT'S NAME (First,	Middle, Lest)	Colleen	A. B	era					MONTH	OF DEATH	AY 100	YEAR	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMB	ER	5. SEX		yrs. last birthday)	thday) IF UNDER 1 YEAR IF UNDER 24 HRS.				March 22, 1993				7:05 A M
P		099-28-4756		1 - M 2 -	57		MONTH			MIN.	(Month, Day, Year)			New S	
3 should		9a. FACILITY NAME (If not ins		9b. C	ITY, TOWN	OR LOCATI	ON OF DE				NTY OF DE	ATH			
1, 2, 3	DIRECTOR	Suburban Ho	ospita EDENT	1			Bethesda					Montgomery			
Ses	Ä	10a. STATE	106, COUNTY			10c. Cf	FY, TOW	N OR LOC	ATION						10d. INSIDE CITY
ij. Pa		Maryland  100. STREET AND NUMBER	М	ontgomer	У			-	Rockvi				LIMITS? 1 VES 2 NO		
physician. burlal-transit permit. Pages 1, 2,	BY FUNERAL	11432 Schuyl	kill R	oad			10f. ZIP CODE 20852						_	ed St	tates
physician burial-tra	5	11, MARITAL STATUS		12. WAS DECEDEN	T EVER IN U	.S. ARMED	1	13. WAS DE	ECENDENT (	OF HISPAN	IIC ORIGIN	(Specify Yes	or No	14. RACE -	- American Indian,
the sta		1 Never Married 2 X   3 Widowed 4 Divor		FORCES?	WAR OR DATE	z X NO	NO If yes, specify Cuben, Mexican, Puerto Rican, etc.)  1  YES 2 X NO Specify: Specify: While								
r attending use as the	8		EDENT'S EDU		10	Ba. DECEDENT'S					16b.	KIND OF BUS	SINESS/ING		
the hospital or detached for u	COMPLET	Elementary/Secondary (0-		College (1-4 or 5		(Give kind of life. Do NOT L	ise retired	d.)		ng	Po	tireme	nt C	ont or	
the hos detach once.	N N	17. FATHER'S NAME (First, Mic	ddie, Last)			Regisce	gistered Nurse Reti							encer	
के विक		John T				i i		orma		Sumame)					
fetained by 5 should be notified at	8						G ADDRI	FSS (Street				r, City or Tow	n Chata 76	Codel	
	유	Dennis W. Be	erg									cville			352
6 ma ctor, p		20a. METHOD OF DISPOSITION 1X Burlal 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (	n 3 🗆 Reme	oval from State	ACE AND DATE	AND DATE of DISPOSITION (Name of 3/26/93 OATE of Heaven Cemetery Silver Spring, Maryl									
Page Il dire	1	21. SIGNATURE OF FUNERAL		ENSEE /	- J Ga	ce or i					CILITY D				cey Funeral
63		Miche	le G	P.Kin	5 M	00348	H	lome/	Rocky	ville Mar	, In	208	00 W. 350-2	Mont	gomery Ave
hours after d of in by the i or removal.		23. PART i. Enter the dis	easea, or o	omplications the	t caused th	ne death. Do	not ent	ter the m	node of dy	ing, aucl	h as cardi	ac or reapi	ratory an	rest,	Approximata
24 hou filled i on, or he m		IMMEDIATE CAUSE (Find disease or condition resulting in death)	ni	List only one cau			24.14								interval Batween Onset and Death
completely ial, cremati		DUE TO (OR AS A CONSEQUENCE OF):													
nd co	NO	Sequentially list condition		CATAL	100 AS A C	DISEQUENCE O	1114	44			_				
sician Mor t	AT	cause. Enter UNDERLYING ISChernic Wait 1, 40,464													
certificate ding physi lygiene pri	F	CAUSE (Disease or Injur that initiated events	, J ,	ONSEQUENCE O	F):	J. 47 ~	-						1		
at the death certificate be ex by the attending physician a and Mental Hygiene prior to y injury, or other traum:	CERTIFICATION	resulting in death) LAST d. D. A. D. ETES & 11. + US													
the at Ment		PART II. Other aignifican	nt condition	contributing to	death but	not reauiting	in the	underivi	DO CRUSA (	alven in	Part i	24a. WAS AN	ALITOPSY	245. 9	VERE AUTOPSY FINDINGS
등 모고 등	EDICAL	PART II. Other aignificant conditiona contributing to death but not read						my in the didentying cause given in Part				PERFOR	MED3	6	NAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
requires been signe of Health	ME										_				YES 2 NO
law requires been of higher of higher of higher and hig	ä														
ENDING PHYSICIAN: The law DR: After this certificate has b ter death with the State Dept. B is marked, or Item 23	SICIAN:	25. WAS CASE REFERRED TO EXAMINER?  1 YES 2 X NO	MEDICAL	HOSPITAL:	FR/Outpetie	ent 3 🗆 DOA	отн	ER:	PLACE OF D						
SICIA certif	PHY	27. MANNER OF DEATH		26a. DATE OF	INJURY	28b. TIA	E OF	28c. IN	Me 5 Re	staence		RIBE HOW II	NJURY OC	CURED	
NG PHYS fter this cast with	ВУР	Natural 5 P	ending restigation	(Month, D	lay, Year)	IN.	JURY M	_	YORK?	□ NO					
OBECTOR: After this certificate has been ORECTOR: After this certificate has been hours after death with the State Dept. of Item 28 is marked, or Item 23 sho	ETED E	3 Sulcide 6 C	could not be atermined	26e. PLACE O building,	F INJURY — etc. (Specify)	At home, farm,	street, f	actory, offi	ice			TON (Street a Town, State)	nd Number	or Rural Roo	rte Number,
DIRECT Hours a Item 2	7	29a. CERTIFIER XX CERTIF	FYING PHYSIC	CIAN: To the beat of	my knowledg	no death none	and ad the	- N=- d=			4. 41.				
1 2 N =	COMPL														and manner as stated.
H H H H	BE 0	29b. SIGNATURE AND TITLE	OF CERTIFIER						29c. LICE	ENSE NUM	IBER		29d. DAT	E SIGNED (A	Vonth, Day, Year)
TO THE HOSPA TO THE FUNERA De filed within 7 IMPORTANT: I	0		clusty m	<i>p</i>					0 2	439	8-	marylan	•	3-2	22-93
		30. NAME AND ADDRESS OF	5/4W	COMPLETED CAUS		(ITEM 27) (Type	Print)	ind				Rochu		D a DA	150
		31. DATE FILED (MONTH) Day, W	<b>.0</b> 3	32. REGISTRA											/

GINSION OF VITAL RECORDS, P.O. BOX 68760,

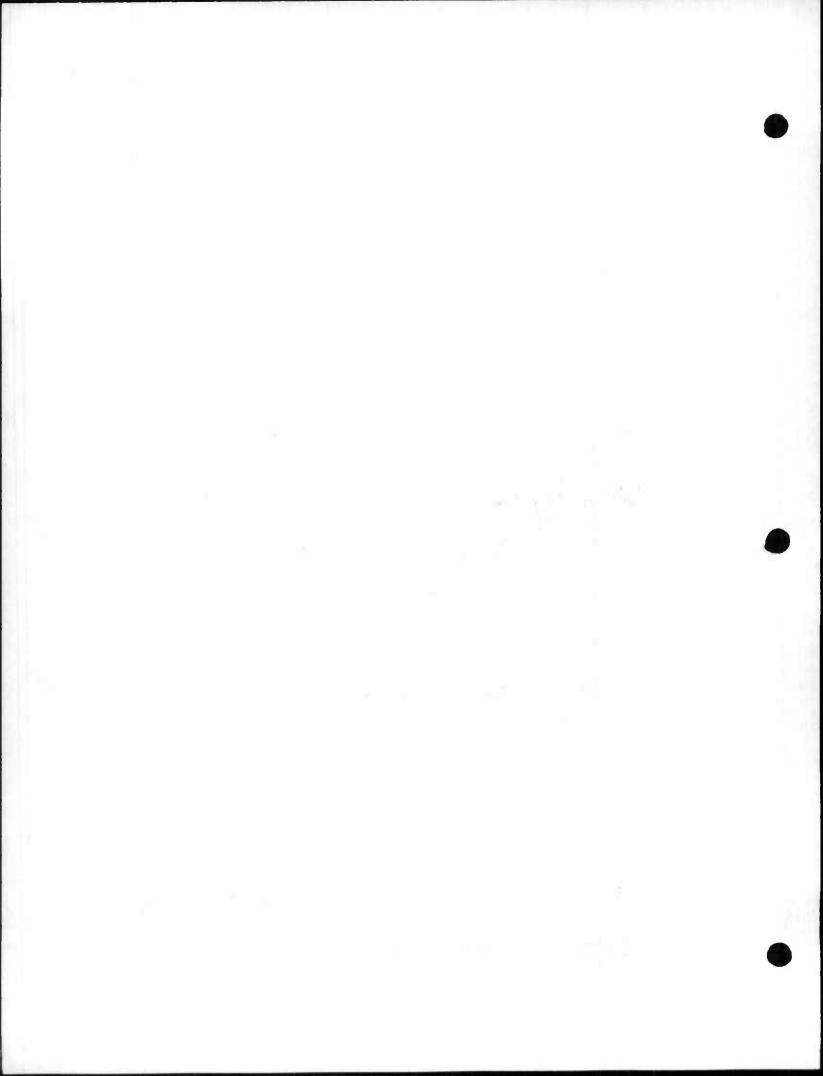
BALTIMORE, MARYLAND 21215-0020



BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	and or arresting PHYSICIAN. The law requires that the death certificate be executed within it	医鼻	100	W
-	6	E #	6.9	F
2	æ	是克	E	ш
0	6	古多	의	7
_	zd.	MARKET	5	1
	5	HA CIRECTOR ATE THE CERTIFICATE has been signed by the attending physician and completely and month of the state Dept. of Health and Mental Hygiene prior to burial, oremain	fullem 28 is marked, or item 23 shows any injury, or other traumatic event, ti	MPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

	1 - FOR STATE OF MARYLE REGISTRAR	AND / DEPARTI	MENT OF H	EALTH AND I	MENTAL HYGIEN	IE .	09033				
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH	-	3. TIME OF CEATH					
	HELEN V. BECKER					8 93	4:00 A M				
	0.4 = 0.4	The second secon	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	HPLACE (State or Foreign					
		U YRS.			1/20/13	MA	RYLAND				
œ	9s. FACILITY NAME (If not institution, give street and number)			R LOCATION OF DE	ATH	9c. COUNTY OF					
OT:	NATIONAL LUTHERAN HOME ROCKVILLE MONTGO										
DIRECTOR	MD. 10b. COUNTY BALTIMORE CITY	MORE		10d. INSIDE CITY LIMITS? XXYES 2 \( \) NO							
FUNERAL	100. STREET AND NUMBER 602- S. MACON STREET	21224	1	10g. CITIZEN OF	WHAT COUNTRY?						
COMPLETED BY FUN	11. MARITAL STATUS  1 Never Merried 2 Married  3 Widowed 4 Divorced  12. WAS DECEDENT EVER IN FORCES? 1 YES GIVE WAR OR DA	ENDENT OF HISPAN acity Cuben, Mexican XXNO Specify	IC ORIGIN? (Specify Yea n, Puerlo Rican, etc.)	or No- 14. RAC Bisc	E - American Indian, ck, White, etc.						
	15. OECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  1 2  College (1-4 or 5+)	16a. DECEDENT'S US (Give kind of work life. Do NOT use no STOF	UAL OCCUPATION of during mostired.)	st of working	16b. KIND OF BUS	SINESS/INDUSTRY					
8	17. FATHER'S NAME (First, Middle, Last)				ME (First, Middle, Malden						
BE	WILLIAM H. LeBRUN				ELIZABET		LEIM				
2	19e. INFORMANT'S NAME (Type/Print) REV.DR. REICHARD				oute Number, City or Town						
	200. METHOD OF DISPOSITION										
	.V. V	ARDEN OF	Place A T T	meof		CATION — City or To					
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	AKDEN OF		O ADDRESS OF FAC		LTIMORI	E,MD.				
	W. M. History		HY	SONG CO	.,INC.						
	23. PART I. Enter the diseases, or complications that caused	the death De set	13	00- N S	TREET, NW	, WASH					
7	IMMEDIATE CAUSE (Final disease or condition resulting in death)	consequence of:	phy	atory	as cardiac or reapi	ratory errest,	Approximate Interval Between Onset and Death				
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avents resulting in death) LAST  b.  UNE TO (OR AS A CONSEQUENCE OF)?  C.  OUE TO (OR AS A CONSEQUENCE OF):										
MEDICAL	PART II. Other algnificant conditions contributing to death be	Part I. 24e. WAS AN PERFORI	MEO?	. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO							
Ž	25. WAS CASE REFERRED TO MEDICAL		26. PL	ACE OF DEATH (Che	ck anh one)						
PHYSICIAN:	EXAMINER?  1 YES XXNO  HOSPITAL:  1 Inputert 2 ER/Output	itlent 3 DOA		5 Residence 6							
È	27. MANNER OF CEATH 26e. DATE OF INJURY	28b. TIME OF	F 28c. INJU	JRY AT	28d. DESCRIBE HOW IN	JURY OCCURED					
ВУ	VXNeturel 5 ☐ Pending  2 ☐ Accident Investigation  (Month, Day, Year)	INJURY		RK? ES 2 NO							
	3 Suicide 6 Could not be determined 28e. PLACE OF INJURY building, atc. (Specific Could not be building, atc.)	At home, ferm, stree	t, factory, office		28f. LOCATION (Street as City or Town, State)	nd Number or Rural F	Route Number,				
BENDOMPLETED	29e. CERTIFIER (Chock only one)  1X CERTIFYING PHYSICIAN: To the best of my knowled one)  2 MEDICAL EXAMINER: On the basis of gramiperton	edge, death occurred at	t the time, date	and piece, end due to	o the cause(e) end men	ner es stated.	t) and manner as stated				
O Benediction	29b. SGNATURE AND TITLE OF CERTIFIER	2 MEDICAL EXAMINER: On the basis of stamportion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end manner as stated.  29b. SGNATURE AND TITLE OF CERTIFIER  29c. LICENSE NUMBER  29d. DATE SIGNED (Month Styr, Meer)									
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEAD DR. CHARLES KARESH- 1 NO	TH (ITEM 27) (Type, Print) • MAIN	STREE!	r, MT.	AIRY, MD.		1				
	31. DATE FILED (MONTH, Day, 1947)  32. AEGISTRAPTS SIGNA MAR 23 93	TURE Randelle									

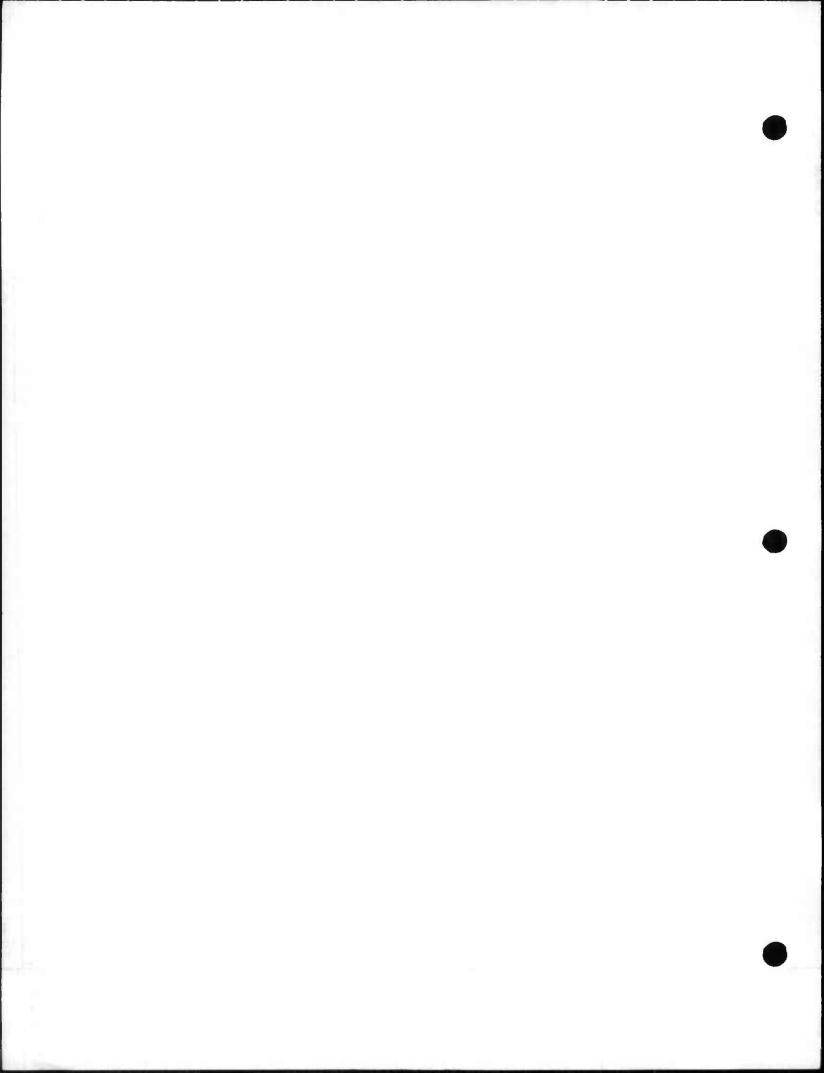


BALTIMORE, MARYLAND 21215-0020

FEMENT. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

8	1. DECEDENT'S NAME (First,	Middle, Last)							2. DATE	OF DEATH	DAY	YEAR	3. TIME OF DEATH
	MARY	С.	BRILL										1:30 A M
	4. SOCIAL SECURITY NUME	ER	5. SEX	8. AGE (In yrs. las	t birthday)	IF UNDER 1 Y		UNDER 24 HRS	7. DATE	OF BIRTH	477	8. BIRTH	PLACE (State or Foreign
	577-48-2225		1 M 2 X F	93	YRS.	MONTHS D	WS HO	URS MIN.	SEP	n, Day, Year)	, 189	9 VII	KGINIA
_	9a. FACILITY NAME (If not institution, give street and number)  9b. CITY, TOWN OR LOCATION OF DEATH  9c. COUNTY OF DEATH											EATH	
DIRECTOR	ALTHEA WOODLAND NURSING HOME SILVER SPRING MONTGOMERY											OMERY	
S	10a. STATE	10b. COUNT	γ		10c, CITY	, TOWN OR L	OCATION						10d, INSIDE CITY
E	MARYLAND	MOI	NTGOMERY		SI	LVER	SPRI	NG					LIMITS?
	10e. STREET AND NUMBER				1		10f. ZIP	CODE			10g. CIT	IZEN OF V	VHAT COUNTRY?
FUNERAL	305 DA	LE DI	RIVE		2091							USA	
3	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. AR	MED	13. WAS	DECEND	NT OF HISE	ANIC ORIGI	N? (Specify Y	es or No-	14. RACE	— American Indian,
BY F	1 Never Married 2 3 Widowed 4 Divo		IF YES, GIVE W	YES 2 XN	Ю		YES 2		can, Puerto	Rican, etc.)		Speci	c, White, etc.
						ı							WILLE
	15. DEC (Specify only	EDENT'S EDU highest grade	CATION completed)	/G/	ve kind of w	OSUAL OCCU	PATION ig most of	working	168	. KIND OF B	USINESS/IN	DUSTRY	
COMPLETED	Elementary/Secondary (0	-12)	College (1-4 or 5	·)	Do NOT use	WOMA	N			C	LERIC.	ΔΤ	
×	17. FATHER'S NAME (First, M	infello ( a ant)		роз	TMESS	WOLLA				7		AL .	
ö	PATRICK	iodia, Lest)	CANA	MAN				FANNI		Middle, Maide		NES	
8	19a. INFORMANT'S NAME (7	vpe/Print)	OAM		MAILING	ADDRESS (S				har Chu ar Ta			
٩	REV. GERARI	P. B	ELL			EDAR							910
	20a. METHOD OF DISPOSITI	n 3 🗆 Rem	oval from State	20b. PLACE A cemetery, cree GATE					3/2		OCATION LVER		wn, State NG, MD
	21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE	01112	02 111	22. NAI	E AND A	DORESS OF	FACILITY				
	tour	un /	Frond							FUNE			
	23. PART I. Enter the di	seases, or o	complications the	t caused the de	ath. Do n	500	UNIV	ERSIT	A BLA	D., W	., SI	L.SP	Approximate
	shock, or h	eart failure.	List only one cau	se on each line		or order un	111000	dynig, s	Jen de cer	uiac or res	pinatory ar	reat,	interval Between
1	IMMEDIATE CAUSE (Findisease or condition	ial	1 (1)	Ara Vil	a a seedal	A	wa-	1					Onset and Death
1	resulting in death)  a												
z			Thes	mator	- fo	alu							Sudden
일	Sequentially list conditi if any, leading to imme-	diate	A DUE TO	OR AS A CONSEC	UENCE OF	Ä							
S	cause. Enter UNDERLY! CAUSE (Disease or inju		a rue	monio	Ma, Azmatum								day
E	that initiated events resulting in death) LAS	,	DUE TO	(OR AS A CONSEC		- 1	1						1. 11
CERTIFICATION			d. UN'N	we hu	terst	and h	3 m	)()					Months
	PART II. Other aignifica	nt condition	a contributing to	death but not re	suiting in	n the under	lying car	se given	in Part i.				WERE AUTOPSY FINDINGS
MEDICAL										1 TYES	2 DLNO		AVAILABLE PRIOR TO COMPLETION OF CAUSE
ij													OF DEATH?
S	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	MORBITAL				6. PLACE	OF DEATH (	Check only o	10)			
XSI	1 TES 2 NO		HOSPITAL: 1 Inpatient 2	ER/Outpetient 3	□ DOA	OTHER:	Home 5	☐ Residenc	8 🗆 Othe	r (Specify)			
PHYSICIAN	27. MAJUNER OF DEATH	Daniel -	28e. DATE OF (Month, D		28b. TIME INJU	OF 28	WORK?	AT	28d. DE	SCRIBE HOW	INJURY OC	CURED	
à		Pending Investigation						2 NO					
		Could not be determined	28e. PLACE O building,	F INJURY — At horetc. (Specify)	me, farm, st	treet, factory,	office		281. LOC	ATION (Street or Town, State	and Numbe	r or Rural R	loute Number,
E,													
릴		IFVING PHYSI	CIAN: To the best of										
-S II					nvestigation	i, in my opini	on, death	occured at t	he time, dete	and place, a	end due to t	he cause(s	and manner on stated
Š	2 MEDI		R: On the basis of e	kaminimon end/or l									, and marrier as stated.
SE COMPLET	29b. SONATURE AND TITLE	CAL EXAMINE		kamination end/or i				LICENSE N			_		(Month, Day, Year)
BE	296. SGNATURE AND TITLE	OF CERTIFIER	m							2	_		N MINNEY
	2 MEDI	OF CERTIFIEF	O COMPLETED CAUS		27) (Type,	Print)	290	D-3		2 m	_		N MINNEY
BE	296. SGNATURE AND TITLE	OF CERTIFIER	O COMPLETED CAUS		27) (Type,		290	D-3		2 1 Spm	_		N MINNEY



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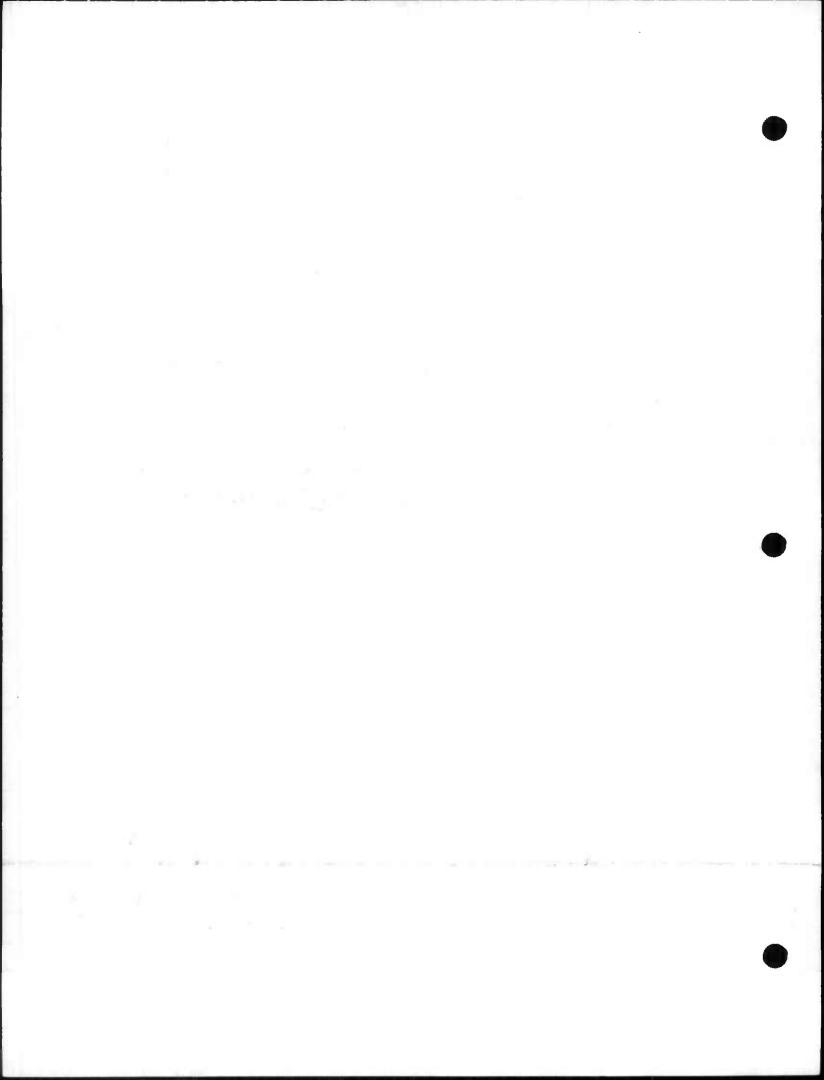
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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mester 0.8 ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or a	E.	뉳	鄞

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1993 Begelman Herman March 20 1:39 AM 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign HOURS 1 M 2 - F YRS. 102-03-0515 Sept 12. 1910 New York 9s. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Shady Grove Adventist Hospital Rockville Montgomery RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Gaithersburg 1 YES 2 X NO FUNERAL 10e, STREET AND NUMBER 10f, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 19007 Mills Choice Road 20879 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Merried If yes, specify Cuban, Mexican, Puerto Ri
1 YES 2 NO Specify: IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 Businessman Automobiles 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Begelman Max Celia BE Galenson 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 9 (Wife) Catherine Begelman Same as #10 20e. METHOD OF DISPOSITION
1 □ Burial 2 □X Cremation 3 □ Re 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State OATE Suburban Crematory 4 ☐ Donetion 5 ☐ Other (Specify) 3-21 Silver Spring, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A. Ch 2) oth 13. 933 Gist Ave, Silver Spring, MD M00827 20910 23. PART/1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, Approximate shock, or heart fellure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Finel Onset and Death disease or condition resulting in death) Metastatic OUE TO (OR AS A CONSEQUENCE OF) anemia CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 20 NO OF DEATH? 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 N Inpetient 2 - ER/Outpetient 3 - DOA 1 YES 2X NO me 5 - Residence 6 - Other (Specify) 26a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 26b. TIME OF 28c. INJURY AT WORK? 26d. DEŞCRIBE HOW INJURY OCCURED 1 Keletural 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — Al home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 6 Could not be COMPLETED 4 Homicide 29e. CERTIFIER (Check only 1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, and dus to the cause(e) and manner as stated. 2 \_\_\_ MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) and manner ea stated. 29d. DATE SIGNEO (Month, Day, Year) 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER Alpuster 3139 3 20 9 30. NAME AND A CORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 20879—2 19261 Montgomery Village Ave #G10, Gaithersburg, Suhair Abulfarag. M.D. 31. DATE FILEO (Month, Day, Year) 32. REGISTRAR'S SIGNATURE MAR 22 '93 whie Davidson Bordell



permit. Pages 1, 2, 3

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filled in by the funeral director, page 5 should be

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signed by the attending physician and completely fille Health and Mental Hygiene prior to burial, cremation,

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	The second or second
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH YEAR P JAMES MATTINGLY BOWIE MAR 22 1993 11:16 A SOCIAL SECTIOITY MIMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 😾 M 2 🗌 F 219-16-1679 MAR 1 1925 MARYLAND Sa. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR NATIONAL NAVAL MEDICAL CENTER **BETHESDA** MONTGOMERY 19c, CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND CHARLES INDIAN HEAD 1 VES 2 NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 503 INDIAN HEAD AVENUE 20640 UNITED STATES 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 TY YES 2 IF YES, GIVE WAR OR DATES 1 Never Merried 2 Married 1 TES 2 NO Specify BY Specify. 3 Widowed 4 Divorced 1941 - 1963 WHITE COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) W.S.S.C. Plant Operator 12 17, FATHER'S NAME (First, Middle, Lest) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ WESLEY BOWIE CLARA DAVIS notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 SYBELLINE BOWLE INDIAN HEAD AVENUE, INDIAN HEAD MD 20640 503 e 20a, METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must correction of the Memorial Gdns 3-2 Waldorf, Md. 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE-MCENSEE Amin Matthews MO O MARCANO ADDRESS OF FACILITY BEILINGS. examiner HUNTT FUNERAL HOME Box 156 Waldorf 20604 medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition NON SMALL CELL LUNG CANCER event. resulting in death) traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (QR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 1 TES ZY NO OF DEATH? Shows 1 ☐ YES 2 ☐ NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF OEATH (Check only one) tem HOSPITAL:
1 Springerlient 2 □ ER/Outpatient 3 □ DOA OTHER: 1 YES 2 NO ng Home 5 - Residence 6 - Other (Specify) 4 Num 6 27. MANNER OF DEATH 26e. OATE OF INJURY (Month, Day, Year) 26c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, 1 X Natural 5 Pending Investiga 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, stc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) .00 6 Could not be COMPLETED 4 Homicide 28 Hern 29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. MPORTANT: II 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER

MO

32. REGISTRAR'S SIGNATURE

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

N. M. SULLIVAN, LT, MC, USNR

31. DATE FILEO (Month, Day, Year) 93

29c. LICENSE NUMBER

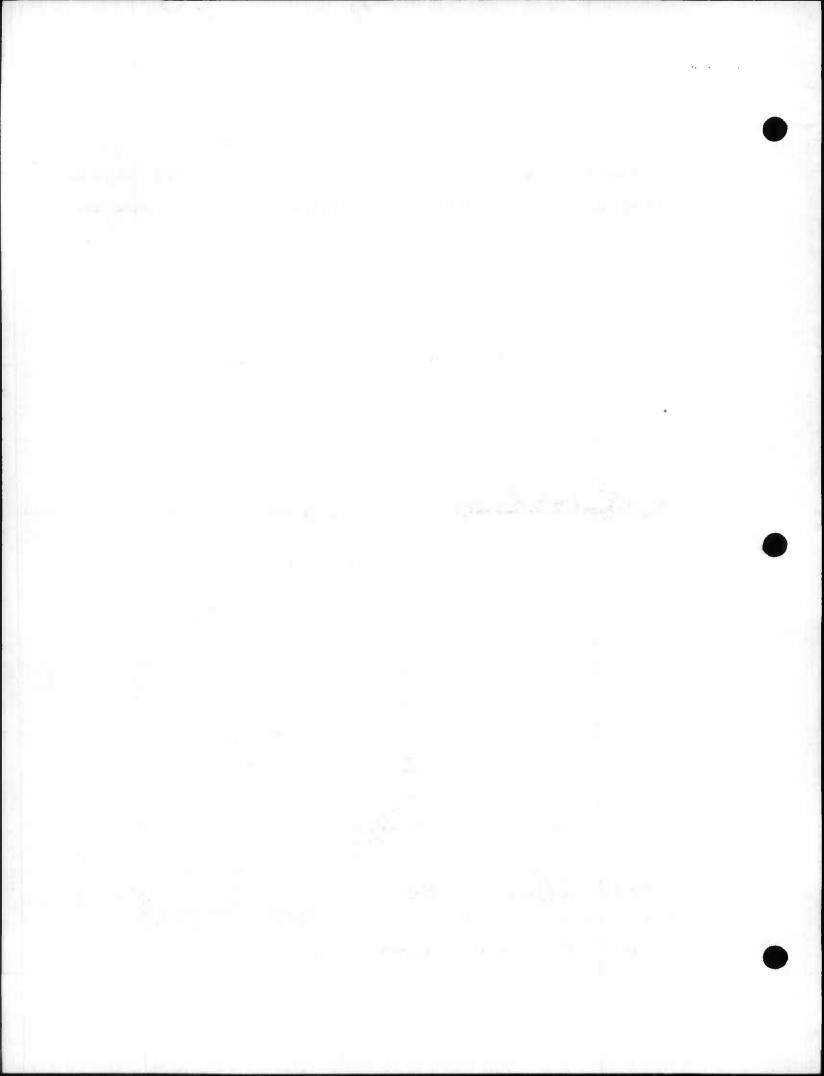
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NATIONAL NAVAL MEDICAL CENTER

BETHESDA, MD 20889-5600

29d. DATE SIGNED (Month, Day, Year)

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BALTIMORE, MARYLAND 21215-00	death. Page 6 may be retained by the hospital or attending I	firmersi director none & chould be dechapted for use or the
	24 hours after d	filled in he the
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2a hours after death. Page 6 may be retained by the hospital or attending I	DIRECTION After this certificate has been closed by the attendion physician and completely filled in his the funeral discovery case is change by the described for use as so that
DIVISION	IL OR ATTENDING PH	DIRECTOR After this

the burial-transit permit. Pages 1, 2, 3 should TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	TEGISTION		- 0.	-1 4 7 11	ICALL	OI.	DEMIL		REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Lest)  2. DATE OF DEATH MONTH DAY YEAR  3. TIME OF DEATH											
	Clarence Ed	ran	Tr			ľ	MONTH D		73	0025 M		
	4. SOCIAL SECURITY NUMBER	dward Bollinger  5. SEX 6. AGE (In yrs. lest birthday)			FUNDER 1 YEAR IF UNDER 24 HRS.							
						DAYS	1	IN.	7. DATE OF BIRTH (Month, Day, Year)		6, BIRTHE	PLACE (State or Foreign
- 1		1 🔀 M 2 🗆 F	6	9YRS.					6 5 19	123	M	D
	Se. FACILITY NAME (If not institution, give s			9b. CITY,	TOWN C	R LOCATION	OF DEAT	ГН	9c. COU	NTY OF DE	ATH	
<u>ب</u>	Carroll County									7 7		
K	RESIDENCE OF DECEDENT	•	Westminster Carroll							11		
DIRECTOR	10a. STATE 10b. COUNTY	,		10c. CIT	TY, TOWN OR LOCATION 104 INSIDE CITY							10d. INSIDE CITY
<b>E</b> I	MD Ca	rroll			1.7							LIMITS?
	10e. STREET AND NUMBER	CITOTI		we:		inste	er				1   YES 2   NO	
₹						101	. ZIP CODE			10g. CIT	IZEN OF WI	HAT COUNTRY?
山	538 Poole Road						2115	7		US		
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. AR	MED	13, W	AS DEC			ORIGIN? (Specify Yes		14. RACE	- American Indian,
	1 Never Married 2 Married	FORCES? 1	YES 2 N	ю	H	yes, sp	ecify Cuban, &	fexican,	Puerto Rican, etc.)		Black,	White, atc.
BY	3 Wildowed 4 Divorced	WWI	YES 2 NA OR DATES			1E3	2 NO	эрвсту:			Specify	white
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물			W	worker					bus c	omp	any	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTHER	'S NAME	(First, Middle, Maiden	Surname)		
	Clarence Edwa	rd Rol	lingen	CI-	n				Bea			
8	19e. INFORMANT'S NAME (Type/Print)	a DOI	TITIECT	NAME INC	ADDRESS	/Da		ua	te Number, City or Town	.111		
2	Mrs. Mary V. E	0771122										
		orrruge	T. 2	20 -	LOOTE	e K	oad,	Wes	stminste	r, I	VID :	21157
	20e, METHOD OF DISPOSITION 1 A Burial 2 Cremation 3 Remo	numl from Ctuto	20b. PLACE	AND DATE	OF DISPOSIT	TION (Na	me of		DATE 20c. LO	CATION -	Cify or Tow	rn, State
	4 Donation 5 Other (Specify)	oval from State	Mead	OW I	Brance)	ch	Cemet	ers	7 3/29	Wee-	tmi n	ster, MD
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		-	22 M	AME AL	IN ANNDESS	DE EACH	ITV			
					Pr	rit	ts Fu	mer	cal Home	& (	Chane	el
	Robert K.	Pritts.	Sr.		41	12	Washi	not	ton Rd	Was	tmi	nster. MD
	23. PART I. Enter the diseases, or o					he mo	de of duing	areata .	es cardina or recal	11 0 1	) OH(12)	Approximate
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events  CHRONIC SIBSTIZECTUS POLINO-AAR DISEASE  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):											
E	resulting in death) LAST											
: MEDICAL	PROBASILE CANCER OF LUNG (NOT TISSUE)  PERFORMED?  1 YES 2 (LINO)										WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 MO	
A	25. WAS CASE REFERRED TO MEDICAL					00.	105 05	44 000				
ᅙᆘ	EXAMINER?	HOSPITAL:			OTHER:		ACE OF DEAT	H (Check	conty one)			
3	1 YES 2 -HO	1 Tripatient 2 🗆	ER/Outpatient 3	□ DOA			e 5 🗆 Reside	ence 8	Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH	28e. DATE OF (Month, De		26b, TIM	E OF 2	28c. INJ	URY AT	2	ed. DESCRIBE HOW II	NJURY OC	CURED	
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BÁ	2 Suleida	20e. PLACE OF	F INJURY At ho	me, farm	street, factor				81. LOCATION (Street o	and Number	or Punel De	uite Number
	4 Homicide Could not be	building,	etc. (Specify)	-,	,	,, 5,,,,	-	- 1	City or Town, Stete)	g IVGIIIUBI	OF THURBI PRO	ore Hornber,
Щ												
COMPLETED	29a. CERTIFIER (Check only one) 1 - EERTIFYINO PHYSIC ONE) 2 - MEDICAL EXAMINE											and manner ee stated.
	296. SIGNATURE AND TITLE OF CERTIFIER						29c. LICENSI	F NUMBE	FR	20d DAY	E SIGNED	Month, Day, Year)
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၉	30. NAME AND ADDRESS OF PERSON W									- 0	12	1173
	14 ONTED 6, L	- AVITA	MD MD	27) (Type,	Print)	>47	N676	0-1	1+63 N	3	min	STER
31. DATE THEO (MONTE) DOY, HOUT 93 BEQUETRAR'S SIGNATURE MAR 2993. Such Evidson-Pan									1			

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29b. SIGNATURE AND TITLE OF CERTIFIED

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32. REGISTRAR'S SIGNATURE w with to so

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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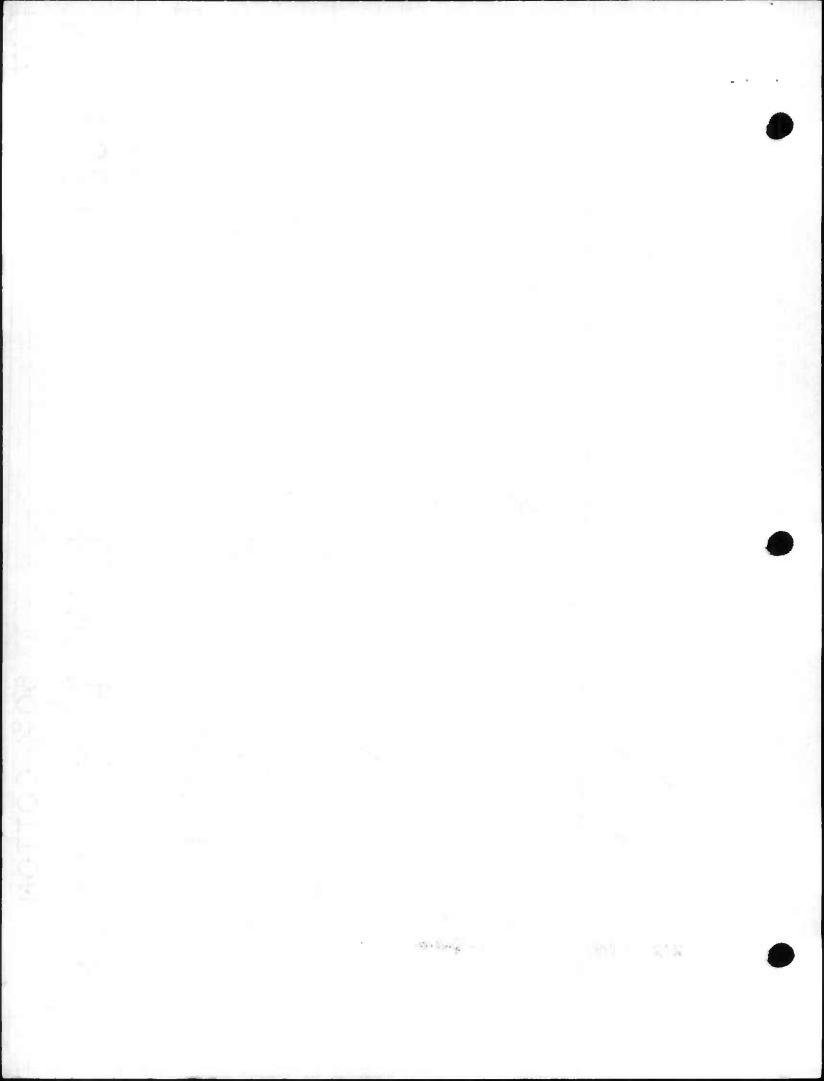
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MONTH 03 1993 Dorothy Davis Bassett 8:55 AM 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year) 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS Dec. 15,1900 DAYS HOURS 1 M 2 XF YRS. Arkansa 460-01-1612 B 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Caroline Nursing Home, Inc. Denton Caroline RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 1 X YES 2 NO Talbot St. Michaels Maryland FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 10f. ZIP CODE U.S.A. 21663 111 W. Chew Ave 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married 3 Widowed 4 □ Divorced Specify: 8 White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 Housewife Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Edward Davis Matilda Cook BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 111 W. Chew Ave. St. Michaels, Md. 21663 Harold S. Bassett 20s METHOD OF DISPOSITION

1 Neurial 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name OATE 20c. LOCATION - City or Town, State Sam Houston VA Cemetery 3-26-93 Houston, Texas ☐ Donation 5 ☐ Other (Specify) \_ 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Harrison E. Leonard Funeral Home e January 60 312 S. Talbot St. St. Michaels, Md. 21663 23. PART I. Enter the diseases, or compilestions that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition resulting in death) Jamers CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury OUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 TYES 2 TOLNO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER 1 | YES 2 | 10 1 | Inpatient 2 | ER/Outpatient 3 | DOA rsing Home 8 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK?
1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCUREO 1 Netural 8 Pending BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner se stated. 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated.

29c, LICENSE NUMBER

29d. DATE SIGNEO (Month, Day, Year)

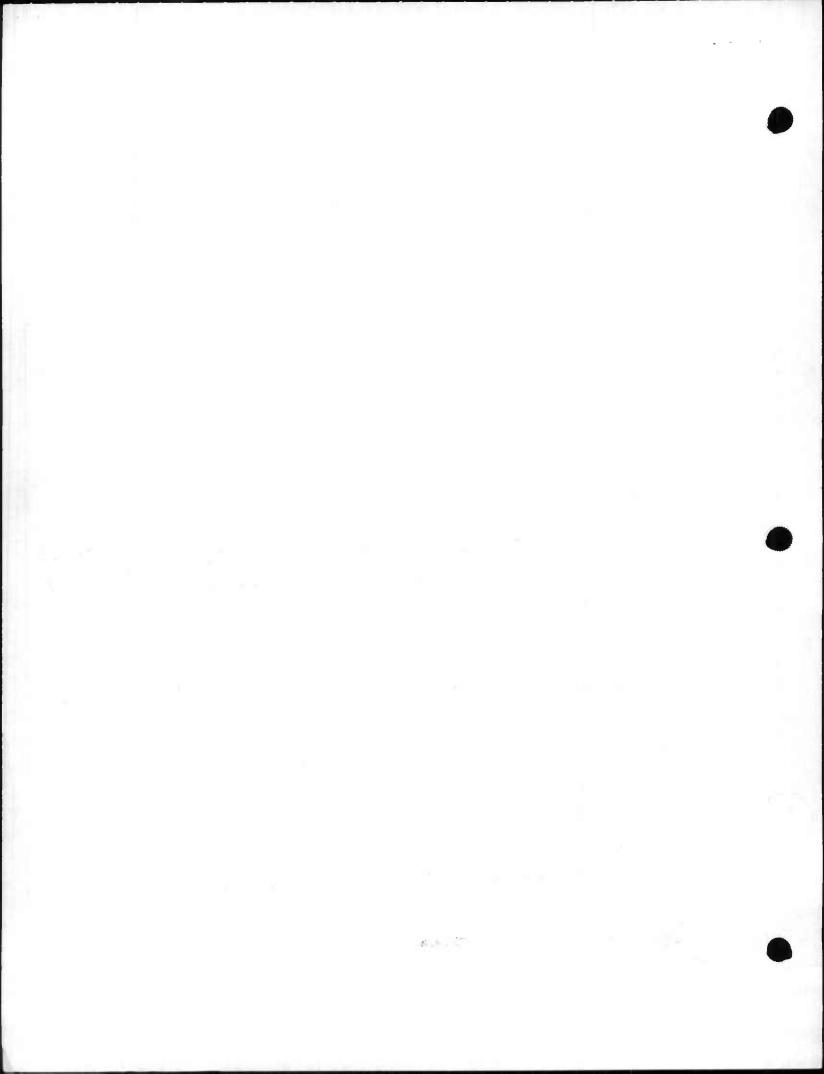


TO THE HOSPIAL OF ATTROBUS AND PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE HUMENAL DIRECTOR AND THIS certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be within 72 hours aftern with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

INPORTANT II thim 28 is marked, or free 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

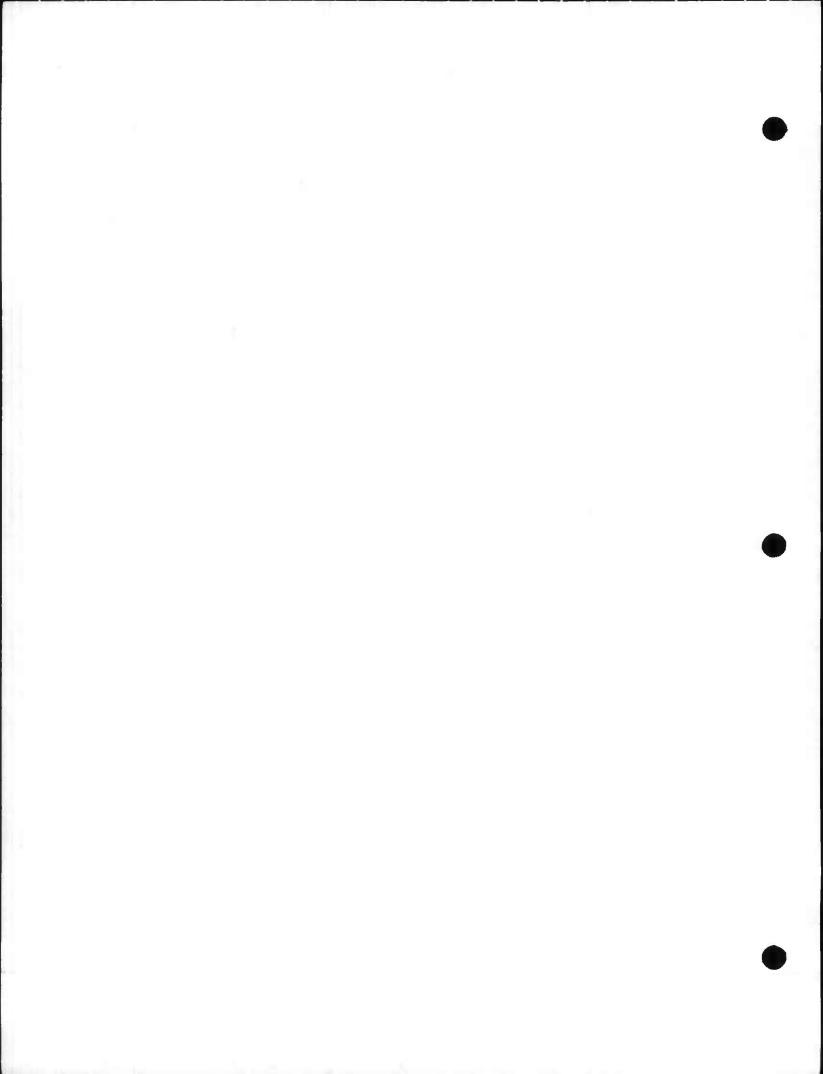
	1 - FOR STATE REGISTRAR	STATE OF MARYL		MENT OF HEALTH A	ND MENTAL HYGIENI	E					
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH				
	-Faye Olivia	Bordley			3 21		м				
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (	HRS. 7. DATE OF BIRTH (Month, Day, Year)	8. BIRT	HPLACE (State or Foreign						
	220-32-0224	1 □ M 2 🔀 F	57 YRS.	ONTHS DAYS HOURS A	4- 15-35		MARYLAND				
· cc	9a. FACILITY NAME (If not institution, give street and number)  9b. CITY, TOWN OR LOCATION OF DEATH  9c. COUNTY OF DEATH										
DIRECTOR	P.O. BOX 332,	PRESTON, MD.		PRESTON		CAROL	INE				
100	10a. STATE 10b. COUNT	Y	10c. CITY,	TOWN OR LOCATION		-	10d. INSIDE CITY				
	MARYLAND CAR	OLINE	PRE	STON			LIMITS?				
₹ N	10e. STREET AND NUMBER			101. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?				
FUNERAL	P.O. BOX 332			21655		USA					
F	11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 VNO	If yes, specify Cuban, R	HISPANIC ORIGIN? (Specify Yea Mexican, Puerto Rican, etc.)		E American Indien, ck, White, etc.				
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	ATES 11	1 TES 2 XNO	Specify:	Spe	cMy: BLACK				
ED	15. DECEDENT'S EDU (Specify only highest grade	JCATION a completed	16a. DECEDENT'S US	SUAL OCCUPATION	16b. KIND OF BUS	INESS/INOUSTRY					
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	k done during most al working etired.)							
MP	11th		MAIN	TENANCE	CHANNE	L MARKE	R				
	17. FATHER'S NAME (First, Middle, Lest)			18. MOTHER	R'S NAME (First, Middle, Maiden S	Surname)					
BE	FINLEY A. BORDI	JEY	40h MAII ING A		TIE E. PIERCE Rural Route Number, City or Town						
2	CLARA FLETCHER										
	20s. METHOD OF DISPOSITION	20b.		BOX 332. PRE		ATION City or 1	own State				
	1 NBuriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)		JOHN'S CE	r place) METERY	3-27-93 PR						
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE		22. NAME AND ADDRESS (			UNERAL SERV.				
				P.O. BOX 10	687 EASTON, M	D. 2160	I				
	23. PAHT I. Enter the diseases, or	complications that caused	I the deeth. Do not				Approximata				
	IMMEDIATE CAUSE (Finel	List only one cause on ac		- 0			Interval Between Onset and Death				
	disease or condition										
	Sequentially list conditions to HYPERTENSIVE CARDIOVASCULAR DISEASE CHYONK										
ON O	Sequentially list conditions,	b. DUE TO (OR AS A	CONSEDUENCE OF:	HULLAND	CUUTIZ DISC	t not	CHOOK				
Ä	If any, leading to immediate cause. Enter UNDERLYING		,				i				
E	CAUSE (Disease or Injury that Initiated eventa	DUE TO (OR AS A	CONSEQUENCE DF):								
CERTIFICATION	resulting in death) LAST	d									
AL C	PART II. Other algorificant condition	ne contributing to death be	ut not reaulting in	the underlying cause give	en in Part I. 24a. WAS AN A	MITOPSY 24	. WERE AUTOPSY FINDINGS				
CA	DIABETES	MELLITT	15		PERFORM	MED?	AVAILABLE PRIDR TO COMPLETION OF CAUSE				
MEDIC		7110010			1 TYES 2	NO	OF DEATH?				
ä			***************************************				I LI TES 2 KNO				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			26. PLACE OF OEAT	H (Check only one)						
YSI	1 VES 2 NO	HOSPITAL: 1   inpetient 2   ER/Outpe		THER:  Nursing Home 5 Reside	ence 8 Other (Specify)						
표	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	26b. TIME C		26d. OESCRIBE HOW IN	JURY OCCURED					
ВУ	2 Accident Investigation	20- 81 405 95 114 114		M 1 YES 2 N							
ED	3 Suicide a Could not be 4 Homicide determined	26e. PLACE OF INJURY building, etc. (Speci	— At home, larm, atre	et, fectory, office	28I. LOCATION (Street an City or Town, State)	nd Number or Rural	Route Number,				
E	29e. CERTIFIER										
COMPLETED					d dua to the cause(a) and mann at the time, deta and place, and		a continue a live				
	29K SIGNATURE AND TITLE OF CERTIFIE										
BE	( R Puson )	nt Lenutz	ME	29c. UCENS	ENUMBER (	29d. DATE SIGNE	(Morth, Day, Year)				
5	30. NAME AND ADDRESS OF PERSON WH	IO COMPLETED CAUSE OF DEA	ATH (ITEM 27) (Type, Pr	int)	LODT	13/2					
	CEJENSA	N MD, 93	09 COA	ikell Rd	DENTO	UMD	21629				
Ì	31. PATE ELLED (Martin, POL 044)	232. REGISTRAR'S SIGN			-						
	111741 N 1000	The state of the s									



## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAN			EHIJEI	CALE	UP DEATH		REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last)						2.	DATE OF DEATH	AY	YEAR 3.	. TIME OF DEATH
		HELEN BURA							ARCH 19,	1993	3	12:35 P M
		4. SOCIAL SECURITY NUMBER 578–18–5833	5. SEX	6. AGE (In yrs. Ia:	t birthday)YRS.	IF UNDER 1 Y	EAR IF UNDER 24 HR AYS HOURS MIT	is. 7. t	Month, Day, Year)		Country)	ACE (State or Foreign INGTON, DC
should		9a. FACILITY NAME (If not institution, give s	treet and number)			9b. CITY, TO	WN OR LOCATION O			9c. COU	NTY OF DEAT	
33	OR	HOLY CROSS HOSPIT	CAL			SILV	ER SPRING	3		MONT	GOMER	Y
	5	RESIDENCE OF DECEDENT  10a, STATE 10b, COUNTY	,		I soo CITY	TOWN OR I	OCATION					
nit. Pages	DIRECTOR		NCE GEORG	ES		ATTSV						INSIDE CITY LIMITS?  YES 2 NO
n. Insit permit.	FUNERAL	7333 NEW HAMPSHI	RE AVE. #	415			101. ZIP CODE 2078:	3				AT COUNTRY?  D STATES
020 physician. bunial-transit	5	11. MARITAL STATUS	12. WAS DECEDENT FORCES? 1	EVER IN U.S. AF	MED		DECENDENT OF HIS			or No-	14. RACE -	- American Indian, White, etc.
	BY	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE W			1 🗆	YES 2 X NO So	pecify:	erto rican, etc.)		Specify:	WHITE
AND 21215-0 the hospital or attending detached for use as the once.	COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	(0	live kind of w	JSUAL OCCU	IPATION ng most of working		16b. KIND OF BUS	SINESS/INC	USTRY	
O 21	الإ	Elementary/Secondary (0-12)	College (1-4 or 5+)		DO NOT use	retired.) READER			II C 00			
AND the hospit detached	N N	17. FATHER'S NAME (First, Middle, Last)		- 1	KOOFF	EADER			U.S. GO		1ENT	
YLA by the be de		HENRY FUTROVSKY					1-1		First, Middle, Maiden GOLDSTEI			
MAR retained 15 should notified	8	19s. INFORMANT'S NAME (Spectros)	7	19	b. MAILING	ADDRESS (S	treet and Number or Ru				Code)	
(t)	2	CHARLES ECTROVSKY	Y (BROTHE				ONTGOMERY					D 20815
RE, may be		20s METHOD OF DISPOSITION 1 K Burlet 2 D Cremellon 2 D Rem	Caret trans trans		ANDDATEO	F DISPOSITIO	ON (Nama of				City or Town	
IMORE Page 6 may Il director, pa		4 Donation & Other (Specify)		EZRAS	ISRA	EL CE	METERY		3-21 CAP	ITOL	HEIGH	HTS, MD
ALTIMORE, death. Page 6 may by funeral director, page I.		21. SIGNATURE OF FUNERAL SERVICE LIC	ENISEE /				ME AND ADDRESS OF ZANSKY—GO			RTAT.	CHAPE	LS INC
AO - 2 M		" Herey	Da 4.1	isl		1170	ROCKVIL	LE I	PIKE, ROC	CKVIL	LE, M	
B, nours after d in by the or removal		23. PART I. Enter the dispuses, or of shock, or heast failure.	complications that	caused the de	ath. Do n	ot enter the	mode of dying,	such as	cardiac or respi	ratory arr	est,	Approximata
	- 1	IMMEDIATE CAUSE (Fine	Ma to	ctato		1115	1 1	100	10. 4.10			Onset and Death
N 123 888		disease or condition resulting in death)	11/2/4	2/4/11	Coll	ruer	of Coi	or /	recion	1		3 MONTUL
2 8 6 H 6			OUE TO	or as a conse	QUENCE OF	): 1 Clv	^	,				20 marth
ecu prid	CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (	OR AS A CONSE	DUENCE OF	):						
BOX zate be ex hysician a prior to	CAT	cause. Enter UNDERLYING CAUSE (Disease or Injury	с.									
. 4 4 4	E	that initiated events	DUE TO (	OR AS A CONSE	DUENCE OF	):						
다 등 등 등 다	Ä	resulting in death) EAST	d			<u>.</u>						-
DS the d Wei		PART II. Other aignificent condition	e contributing to d	feeth but not	resulting in	the unde	rlying ceuse given	in Part	i. 24s. WAS AN			ERE AUTOPSY FINDINGS
OH that	EDICAL								PERFOR		00	MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?
	ME											YES 2 NO
AL RE le law requi has been s Dept. of H	ÿ											
VITAL IAN: The law tificate has the State Dept	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER:	88. PLACE OF DEATH	(Check o	nly one)			
F VIT, SICIAN: Th certificate the State , or Item	17S	1 VES 2 NO	1   Inpatient 2		□ DOA	4 - Nursing	Home 5 🗆 Residen					
NG PHYSIC frer this cereath with the	PHY	1 Natural 5 Pending	28a. DATE OF I (Month, Day		28b. TIME INJU	IRY	C. INJURY AT WORK?	- 1	DESCRIBE HOW II	NJURY OC	URED	
ON VDING STEER TO GEATH	BY	2 Accident Investigation 3 Suicide 6 Could not be	28a. PLACE OF	INJURY — At he	ome, farm, st			_	LOCATION (Street s	and Number	or Burel Bou	te Number
ISI TTEN TOR: after	回	4 Homicide 6 Could not be determined	building, e	tc. (Specify)					City or Town, State)	774 774711207	07 110141 71001	
DIV OR A DIREC DIREC Hours	LE I	29e. CERTIFIER (Check only	CIAN: To the best of n	ny knowledge, de	eth occurred	d at the time.	data and place, and	due to th	e cause(e) and man	oner on stat	ed	
医 温度 三	COMPLET	one) 2 MEDICAL EXAMINE										nd manner as stated.
		296. SIGNATURE AND TITLE OF CERTIFIE					29c. LICENSE		_			lonth, Day, Year)
MPOR IN	3 BE	1 xuu a. 19	7 Wer. M	1			1244	16	7			19, 1993
12	٩	30. NAME AND ADDRESS OF PERSON WHI										
0		BRUCE SILVER, M.D			PARK	DRIVI	E, #201	SILV	ER SPRIN	IG, M	D 20	902
		31. DATE FILED (Month, Dey, Year) MAR 22 '93	32. REGISTRAR	'S SIGNATURE	and as							

Julia Davidson Randoll



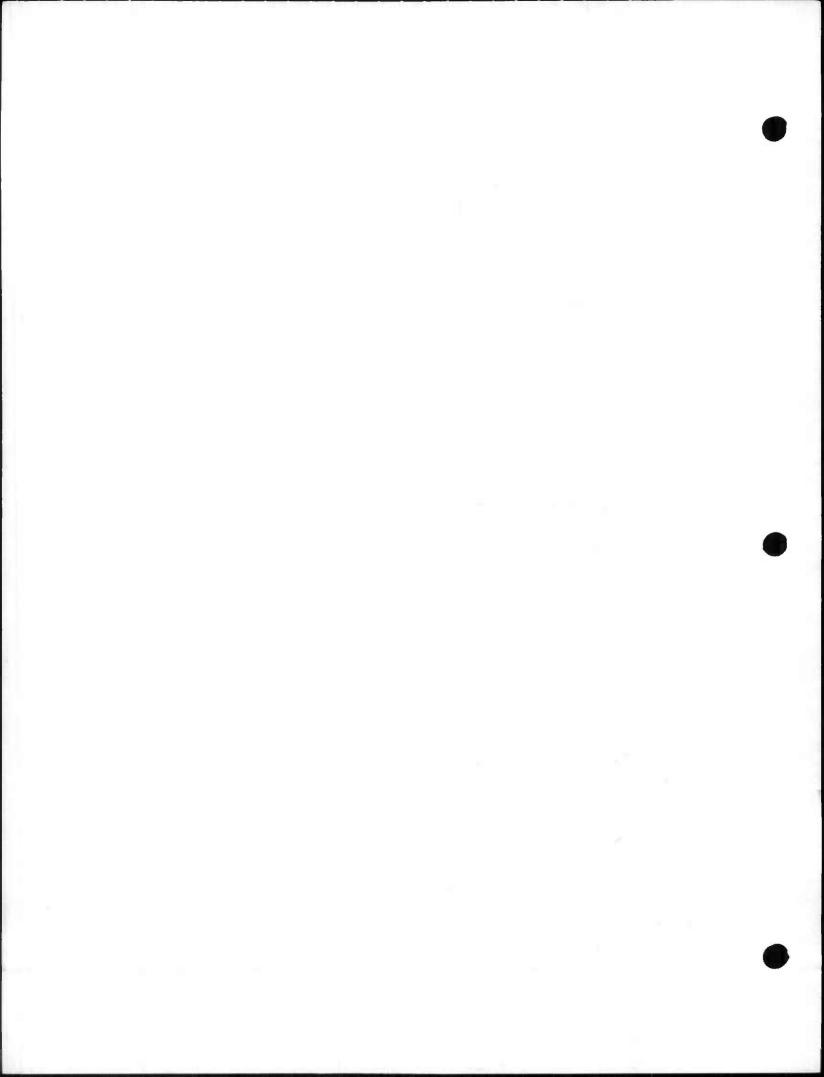
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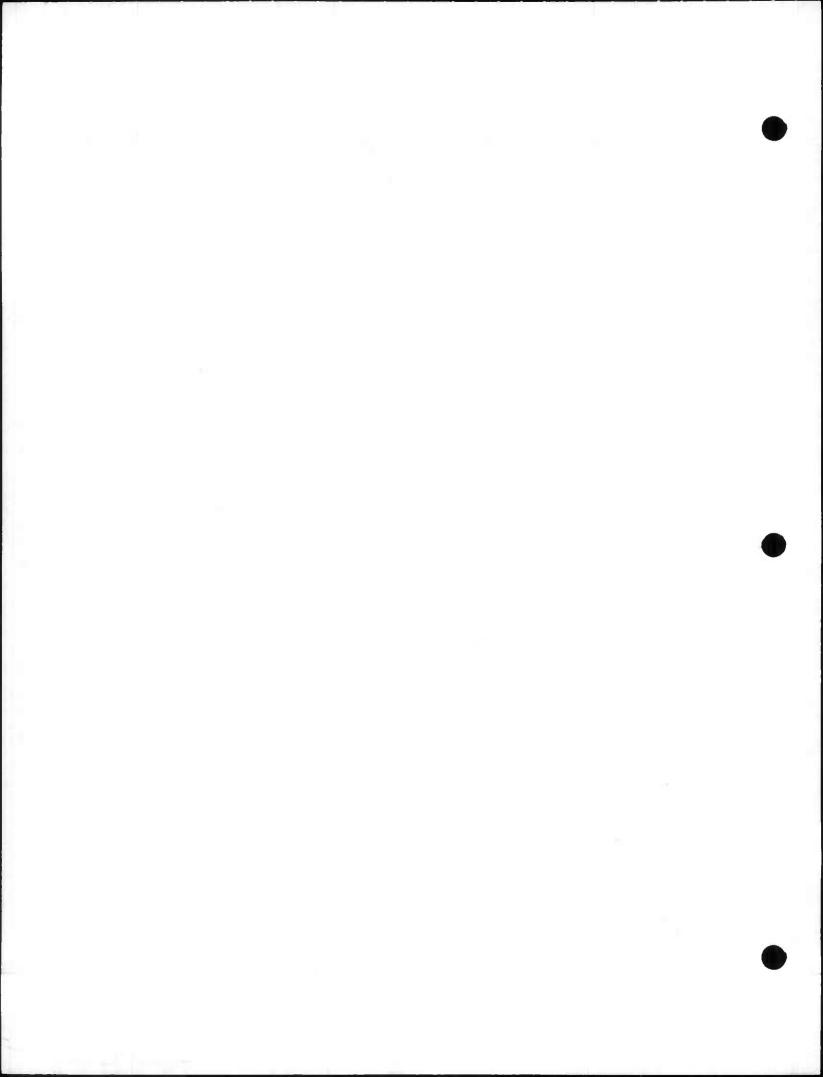
		LAWRENCE  4. SOCIAL SECURITY NUMBER		E (In yrs. lest birthday) IF UP	DER 1 YEAR IF UNDER 24 HRS	3	BIRTH 1 21/12 //	3. TIME OF DEATH 3. 339 M (BIRTHPLACE (State or Foreign Country)
UZU physician. buria-transit permit. Pages 1, 2, 3 should	NC.	311-40-8110  Da. FACILITY NAME (I' not institution, give:  Shady Grove A		52 YRS. MONTH	TTY, TOWN OR LOCATION OF	12	9c. COUNTY	ndiana Y OF DEATH
	DIRECTO	10a. STATE 10b. COUNT			n or Location rsburg	/ //(3)	1 () 107	10d. INSIDE CITY LIMITS  1  YES 2  NO
	NERAL	10%. STREET AND NUMBER  846 Quince Orchar  11. MARITAL STATUS	d Blvd. Apt.	.#102	101. ZIP CODE 20878		U.S.	N OF WHAT COUNTRY?
	BY FUN	1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 TYPES IF YES, GIVE WAR OR 1959-1962	S 2 NO	13. WAS DECENDENT OF HISE If yea, specify Cuban, Mex 1 YES 2 N NO Spe	Ican, Puerto Ric	Specify Yes or No — 14 an, etc.)	D. RACE — American Indian, Black, White, etc. Specify: White
D 2121 Spital or att	IPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		16a. DECEDENT'S USUA. (Give kind of work do life. Do NOT use retiral  Computer P	ne during most of working d.)		. Governme	
of the pa der	BE COMP	17. FATHER'S NAME (First, Middle, Last) Walter Balcerak  19a. INFORMANT'S NAME (Type/Print)			18. MOTHER'S Gwendo	NAME (First, Mid Lyn Wal	de, Maiden Sumame) .lace	
5 5 5	5	Valaria M. Latham  20a. METHOD OF DISPOSITION 1 Burlai 2 X Cremation 3 Rem	20	6429 Ive	ESS (Street and Number or Aur  7 Terrace Dr  POSITION (Name of			gia 30059
BALLIMORE, after death. Page 6 may b y the funeral director, pag- moval.	100	4 Donation 6 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LI	M		Crematory 22. NAME AND ADDRESS OF De Vol Funera	FACILITY		a, Virginia
executed within 24 hours and completely filled in to burial, cremation, or remarke event, the mediants	: MEDIC	IMMEDIATE CAUSE (Final)	a. ATHEROS DUE TO (OR AS	ed the death. Do not en each line.	CORONARI	uch as cardia	c or reapiratory arres	interval Between Onset and Death
th certificate anding plays I Hygiene p		CAUSE (Disease or injury that initiated events resulting in death) LAST	d	A CONSEQUENCE OF):				
ON ATTENDING PHYSICIAN: The law requires that the deal DIHECTOR: After this certificate has been signed by the atteines after death with the State Dept. of Health and Mentalium 28 is marked, or from 23 shows any injury,		PART II. Other algnificant condition DIABETE		but not resulting in the	underlying cause given		4e. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
	SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? released	HOSPITAL:	ОТН	26. PLACE OF OEATH (	Check only one)		1
	ETED BY PHY	1 X YES 2 - 40 May I e  27. Manner of Death  1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJURY AT WORK? 1  YES 2 NO	1	Specify) HIBE HOW INJURY OCCUP	NED
		3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
THE ENSEMBLE OF THE CONTRACT O	COMPL		ER: On the besie of examinati			he time, date an	d place, and due to the o	ause(e) and manner as stated.
D THE	TO BE	Marlere  30. NAME AND ADDRESS OF PERSON WITH	Haym	an, MD	. MD	) 313	62 ≥ 3	1GNED (Month, Day, Year) 2-20-93
\		MARLENE HAY  31. DATE FILEO (Month, Day, Year)	MAN, MD.	501 N. FR	EDERICK M	9€., C	MITHERS	BURG his
		MAR 22 'Q2	Lulia Karist	. 70. 000				

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



THE HOSP ALL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or a TO HE METALL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for us be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.  TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
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	REGISTRAR	MARYLAND / DE CERT	PARTMENT TIFICATE			ENTAL HYGIEN REG. NO	E	0000
	John Copsey	n Copsey B	rady AOV		2	DATE OF DEATH 3	17/93	3. TIME OF DEATH  9:20 A M
	4. SOCIAL SECURITY NUMBER  235-20-1419  5. SEX  1	6. AGE (In yrs. last birth	res. MONTHS	DAYS HOURS	MINI.	(Month, Day, Year)	. [ '	BIRTHPLACE (State or Foreign Country) 2St Virginia
œ	9a. FACILITY NAME (If not institution, give street and number)			TOWN OR LOCAT	TON OF DEAT	Н	9c. COUNTY	OF DEATH
DIRECTOR	Frederick Memorial Hospit	<u>a</u> L	Fred	erick			Frede	rick
BE	10a. STATE 10b. COUNTY	100	c. CITY, TOWN OF	LOCATION				10d. INSIDE CITY LIMITS?
	Maryland Frederick	F	rederic					1 💢 YES 2 🗌 NO
RA	TOT. ZIP CODE 109. CITIZEN OF WHAT COUNTRY?							
NO.	11. MARITAL STATUS 12. WAS DECEDE	NT EVER IN U.S. ARMED	13. W			ORIGIN? (Specify Yes	U.S.A	
ВУ F		YES 2 NO	H		an, Mexican, I	Puerto Rican, etc.)	1	RACE — American Indian, Black, White, etc. Specify:
	16. DECEDENT'S EDUCATION	14. 050505		***			<u> 167                                    </u>	White
ETE	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5	(Give kir	ENT'S USUAL OC: nd of work done di VOT use retired.)		ing	16b. KIND OF BUS	SINESS/INDUST	TRY
APL	5+		etician	l		U.S. G	overnm	ent
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				THER'S NAME	(First, Middle, Maiden		
BE	Alvey Pearre Brady					san Stiff		
2	190. INFORMANT'S NAME (Type/Print)  John R. Brady					te Number, City or Tow		de)
	20a METHOD OF DISPOSITION 1 IX Burlel 2 Cremation 3 Removal from State	20b. PLACE AND D			rederi	ck, MD 2	1701 CATION — City	or Your State
1	1 [X Burlel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Arlingto	ry or other place)		m .	J		Virginia
	21. SIGNATURE OF FUNERAL SERVICE INCENSEE	Jan Linger	22, N	AME AND ADDR	ESS OF FACIL	ITY	Ingcon,	VIIginia
	120.5.						ithersh	ourg, MD 20877
	23. PART I. Enfer the diseases, or complications the shock, or heart) failure. List only one call IMMEDIATE CAUSE (Final disease or condition resulting in death)	use on each line.	Do not enter t	he mode of d	ring, such a	s cardiac or respi	ratory arrest,	Approximate interval Between Onset and Death
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury	O (DR AS A CONSEQUENT) OR AS A CONSEQUENT OR AS A CONSEQUENT	ion	Se	ptio	cemia		
Ö	PART II. Other significant conditions contributing ty	ndeath but not requit	ting in the und	leriving cause	ghan in Da	- 1   n- uno au	412manay 1	
: MEDICA	Diabetes, h	nemia			gwon ni rai	rt I. 24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMULABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
IAN	25. WAS CASE REFERRED TO MEDICAL			26. PLACE OF	DEATH (Check	only one)		
SIC	EXAMINER?  1 VES 2 NO HOSPITAL: 1 Inpetient 2	☐ ER/Outpatient 3 ☐ D	OTHER:			Other (Specify)		
BY PHYSICIAN:	27. MANNER OF OEATH  1 Netural 5 Pending (Month, 1) 2 Accident Investigation		28d. OEŞCRIBE HOW INJURY OCCURED					
COMPLETED B	3 Suicide 28e. PLACE (	OF INJURY — At home, for etc. (Specify)	arm, street, factor	ry, office	20	61. LOCATION (Street a City or Town, State)		lural Route Number,
PLE	29e. CERTIFIER (Check only	f my knowledge, death o	ocurred at the tim	ne, date and plac	e, and due to	the cause(a) and man	mer as stated.	
MO	one) 2 MEOICAL EXAMINER: Do the beels of							use(s) and menner as stated.
BE C	290. SUPPLYTHE AND TITLE OF CERTIFIER	16		29c. LIC	ENSE NUMBE	R	29d, DATE SIG	GNED (Month, Day, Year)
TO B	30. HAME AND ADDRESS OF PERSON WHO COMPLETED CAL	ISE OF DEATH (ITEM 27)	(Type, Print)		35	183	<b>3</b>	117/93
	31. DATE PILED (Month), Day, Year) 32. REQUESTR	TEG AR'S SIGNATURE		w 9.	50	+ Fr	ederi	ck, MD
	MAR 22 '93	Savidson Box	delle					



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

THE PLEATINE OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should be filled may after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

	1 - STATE OF MARY	LAND / DEPARTMENT OF CERTIFICATE OF	HEALTH AND ME	ENTAL HYGIENE REG. NO.	23	0300	3	
	1. DECEDENT'S NAME (First, Middle, Last)			. DATE OF OEATH		3. TIME OF DEATH		
è	LUISE BOLHO	OFF	1.3	MARCH 17		9:05	TOM	
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AG	E (In yrs. lest birthday) IF UNDER 1 YEAR	IF UNDER 24 HRS. 7.	DATE OF BIRTH	8. BIRTH	PLACE (State or Fore	ign	
1	578-07-5079  1 M 2 M F  9a. FACILITY NAME (If not institution, give street and number)	88 YRS. MONTHS DAYS		(Morth, Day, Year) UNE 8.1	904 C	ERMANY		
DIRECTOR	SHADY GROVE ADVENTIST	110111	CKVILLE	4	9c. COUNTY OF D			
3EC	10a. STATE 10b. COUNTY	10c. CITY, TOWN OR LOC	ATION			10d. INSIDE CITY		
	MD. MONTGOMERY	ROCKVI	LLE			LIMITS?	0	
FUNERAL	10a. STREET AND NUMBER	1	IOF. ZIP CODE	DE 10g. CITIZEN OF WHAT				
NE	199 ROLLINS AVE.		20852		U.S	.A.		
5	11. MARITAL STATUS 1 Never Married 2 Married 12. WAS DECEDENT EVER	S 2 NO If yes, 1	ECENDENT OF HISPANIC (	ORIGIN? (Specify Yes	or No- 14. RACE	- American Indian, White, atc.		
BY	3 Wildowed 4 Divorced IF YES, GIVE WAR OR		NO Specify:	3010 1110211, 3101,	Specifi	y:		
0	15. DECEDENT'S EDUCATION	16a. DECEDENT'S USUAL OCCUPAT	TION	16b. KIND OF BUSI	NEGO (INDUSTRY	WHITE		
	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind of work done during n life. Do NOT use retired.)	nost of working	160. KIND OF BUSI	NESS/INDUSTRY			
AP	8	OWNER		CTI	FT SHOP			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	- Onnie	18. MOTHER'S NAME	(First, Middle, Maiden S				
BE	ERNST MERTENS		UN	KNOWN	EMD	EN		
5	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street	and Number or Rural Route	e Number, City or Town,				
-	GUSTAV H. BOLHOFF	SAME AS	ITEM #1	0				
		0b. PLACE AND DATE OF DISPOSITION (	Name of	DATE 20c. LOC	ATION — City or Too	vn, State		
	4 Donation 5 Other (Specify)	emetery, crematory or other place) CHAMBERS CREM	MATORY 3	/20 R	IVERDAL	E. MD.	ı	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME /	AND ADDRESS OF FACILITY	TY		ING, MD		
	M.W. (Kamberal	M00091 W. V	V. CHAMBE			20910		
	23. PART i. Entar tha diseasea, or complications that caus	ed the death. Do not enter the m	oda of dying, auch as	s cardiac or reapire	atory arreat.	Approximate		
	IMMEDIATE CAUSE (Fine)	aach lina.				Interval Baty	veen	
	disease or condition resulting in death)	us duoh c	Cashino	TANCIL	Das d	1 100 10	)	
	DUE TO (OR AS	A CONSEQUENCE OF:						
Z	Sequantially list conditions,	neuha di	Yeu all	Sheir	new to	pe		
Ĕ	if any, leading to immediate cause. Enter UNDERLYING	A CONSEQUENCE OF):		0.	(			
5	CAUSE (Disease or Injury C.							
Ē	that initiated events resulting in dasth) LAST	A CONSEQUENCE OF):						
CERTIFICATION	d					-		
A	PART II. Other eignificant conditions contributing to death	but not resulting in the underlyle	ng cause given in Part	t i. 24a. WAS AN A	UTOPSY 24b.	WERE AUTOPSY FIND	INGS	
8				PERFORM	7 NO.	AVAILABLE PRIOR TO COMPLETION OF CAU	SE	
N N						OF DEATH?		
PHYSICIAN: MEDIC								
ఠ	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	26. F	PLACE OF DEATH (Check o	only one)			$\neg$	
YS.	1 ☐ YES 2 X NO 1 ☐ Inpetient 2 ☐ ER/Ou	itpatient 3 DOA 4 Nursing Hor	me 5 Realdence 6	Other (Specify)				
표	27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF 28c. IN		d. DESCRIBE HOW INJ	URY OCCURED		$\neg$	
à l	1 Natural 5 Pending 2 Accident Investigation	M 1 🗆	YES 2 NO					
<u>a</u>	3 Suicide 8 Could not be determined 28e. PLACE OF INJUF building, etc. (Sp	RY — At home, larm, street, factory, officially)	CB 281	LOCATION (Street and City or Town, State)	d Number or Rural Ro	ute Number,		
4								
COMPLE	29a. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of my known one)  2 MEDICAL EXAMINER: On the basis of examinet	wiedge, death occurred at the time, dat	e and place, and due to th	he cause(a) and manno	or as stated.			
	29b. SIGNATURE AND TITLE OF CERTIFIER	on and or any agent on, an my opinion,			due to the cause(a)	and manner as state	d.	
88	& WALLE OF CENTIFIER	/	29c. LICENSE NUMBER	IN	1941. DATE SIGNED	Morm gray gray		
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF	WATER COMMAND OF THE PARTY OF T	1 ) ) ) !	IV	- 2/1	0/75		
	SUHAIR H. ABULFARHG		ONTGOMERY	Z TATT TAG	AITHERS	BURG, N	MD.	
1	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIG	NATURE	ON TOOMER)	r villaG	E AVE,		_	
- 1	MAR 22 '02 dulia Teus	dry Bando 02						

214 DW F A.S 1975 . V\* 8821 

ITEMS: 23 PART I, 27, 28a-f, PER MEO G-698 4/8/93 t.t 93 09664

		1 - STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.											
		1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF			YEAR 3.	. TIME OF DE	EATN
		JOSEPH	SCOTT				ELL		03	0	6 9	93 5	:43	P.
pino		4. SOCIAL SECURITY NUMBER  220-19-7236	XXM 2 □ F 17	(In yrs. lest birthda YRS.	MONTHS	DAYS	HOURS	R 24 HRS. MIN.		BIRTH Day, Year) -1975	5 M	lary	ace (State or land	Foreign
1, 2, 3 should	CTOR	99. FACILITY NAME (If not institution, give a DORCHESTER GEN RESIDENCE OF DECEDENT	and a second	TAL		y, town o		ION OF DEA	UTN		DORC			
iit. Pages	DIRE	10a. STATE 10b. COUNT	oline		rest		ION						Dd. INSIDE CI LIMITS?	
in. ransit perm	FUNERAL	100. STREET AND NUMBER 22575 Hog Cree				101	216	_			USA		AT COUNTRY	?
21215-0020 al or attending physician. for use as the burial-transit permit. Pages 1,	B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 XNO		If yes, spi	ecity Cube	OF NISPANIC an, Maxicon, Specify:	, Puerto Ric	(Specify Yes en, etc.)	or No 14	Black, W Specify:	American in White, elc.	idlen,
21 21 for u	COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	UCATION to completed) College (1-4 or 5+)	life, Do NOT	of work done i use retired.)	during mo.		ing	16b. K	IND OF BUS	SINESS/INDUS		11.00	
YLAND by the hospit be detached at once.	OME	17. FATNER'S NAME (First, Middle, Last)		Stude	II U		18. MOT	HER'S NAM	E (First, Mid	Idle, Maiden S	Sumama)			
	BE C	Ernest James	Bell								Brown			
	5	190. INFORMANT'S NAME (Type/Print) Eileen D. Bel	1								n, State, Zip Co		21255	
RE, nay be page		ese METHOD OF DISPOSITION 442 Burlel 2 Cremetton 3 Rem	206.	. PLACE AND DAT	E OF DISPOS	SITION (Na		Roa	ad, I	_	ton,			)
IMORE Page 6 may Il director, pa		4 Donation 5 Other (Specify)		metery, crematory of	der	Ceme	eter	y 3	3-10		eston			355
		21. SIGNATURE OF FUNERAL SERVICE LIC	A-000E		N.	ewna	am F	uner	cal F	Home,	P.A.			
BALT rs after death. n by the funera removal. rdical exami	-	23 PART I Enter the diseases or	MERCERO	2 CES	12	00 5	S. H	Iarri	ison	St.,	, Eas	ton.		2160
24 hours filled in t ion, or red		IMMEDIATE CAUSE (Finel	e. BUTANE INTO	OXICATIO	0 N	the mo	de of dy	ing, such	ss csrdle	c or respir	ratory scres	t,		mata Bstween ind Dsath
coecuted and con burial,	ATION	Sequentielly liet conditions, if sny, lesding to immediate cause. Enter UNDERLYING	b. OUE TO (OR AS A											
certificat nding phy Hygiene p	CERTIFICATION	CAUSE (Diseese or Injury that initiated events resulting in deeth) LAST	DUE TO (OR AS A CONSEQUENCE OF):											
S, F e death he atte Mental Jury, c		PART II. Other significant condition	ns contributing to deeth b	out not resulting	a in the u	-deriving		chan in P		- Imp AN		T		
RECORI requires that the en signed by of Heatth and thows any In	: MEDICAL		To contributing to asset.	dt not resulting	g m me e.	Idenymy	Cansa 3	given in Fa		PERFORM	MEO?	CO OF	ERE AUTOPSY MILABLE PRIO MPLETION OF DEATH?	F CAUSE
	IYSICIAN:	25. WAS CASE REFERRED TO MEDICAL				26. PL	ACE OF D	DEATN (Checi	ck only one)					
OF VITAL PHYSICIAN: The law this cartificate has I the State Dept we or Item 23	YSIC	EXAMINER?	HOSPITAL: 1   Inpatient 2X ER/Outp	petient 3 🗆 DOA	OTHEI 4   Nur		6 5 🗆 R4	esidence 6	☐ Other (5	Specify)				
	BY PH	27. MANNER OF DEATN  1 Natural Strumding 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year) 3 - 6 - 9 3	UN		1 🗌 Y	RK? (ES 2)	NO Z	SUBJE		NHALED		ANE	
DIVISION OR ATTENDING R DIPECTOR: ANY HOURS AN	ERED	3 Suicide 8 Could not be determined	FOUND IN A	AUTO_					Hurl c	Town, State)	<i>nd Number or</i> Acaden Marvla	nt St	e Number, reet	
DIN HOSPITAL OR FUNERAL DIP WITHIN 72 HOW TANT: If HOW	COMPL	2 MEDICAL EXAMINE	SICIAN: To the best of my knowle ER: On the bacle of examination										nd manner es	stated.
TO THE HOSPITAL TO THE FUNERAL De filed within 72 P	TO BE	296 SIGNATURE AND TITLE OF CERTIFIES  30. NAME AND ADDRESS OF PERSON WH	Yhull					ENSE NUMB			29d. DATE SI ▶3 – 7		onth, Day, Yea 93	9
_		MARY MONTH, Day, Year)	KORELL MY	1111		St	reet	., Ва	altir	nore,	, Mar	ylaı	nd 2	21201
	,	100 00 1000	40 . 50 1 - 6	A . O. B.									¥	

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## BALTIMORE, MARYLAND 21215-0020

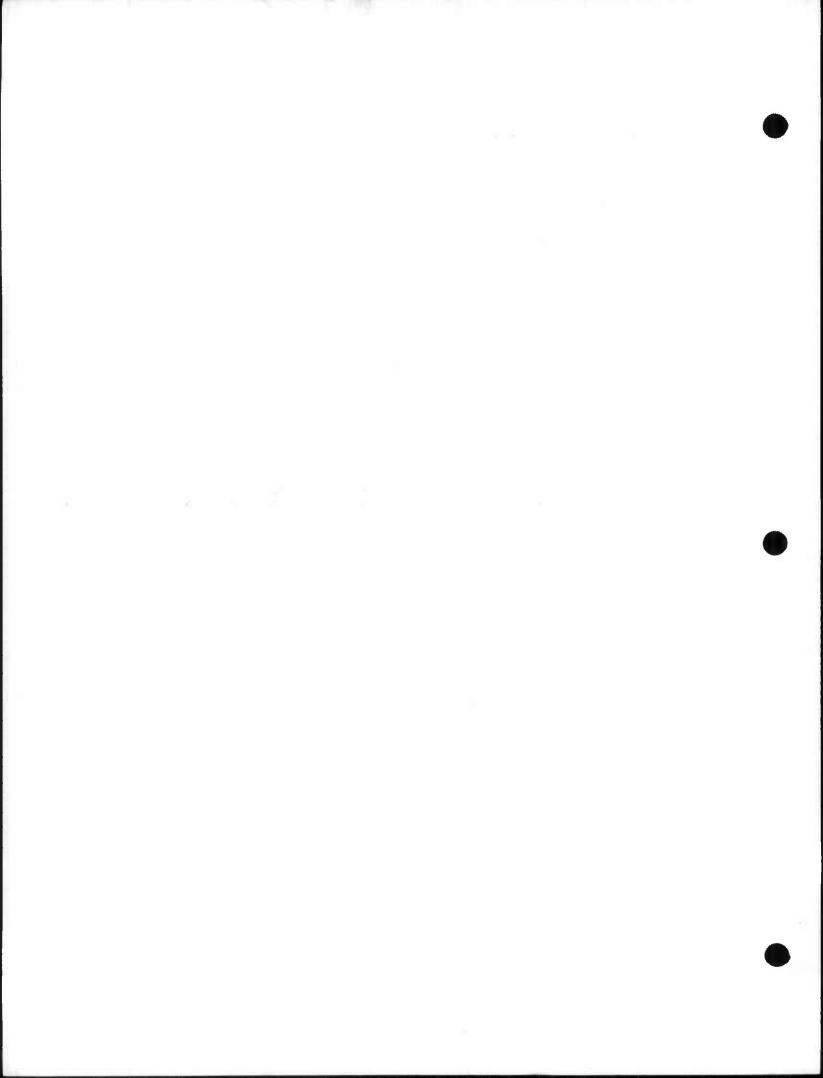
1 -

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE OSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 should	within/22 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	OPITIANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netified at once.
THE TOTAL	THEFUN	Tim Re	PORTA

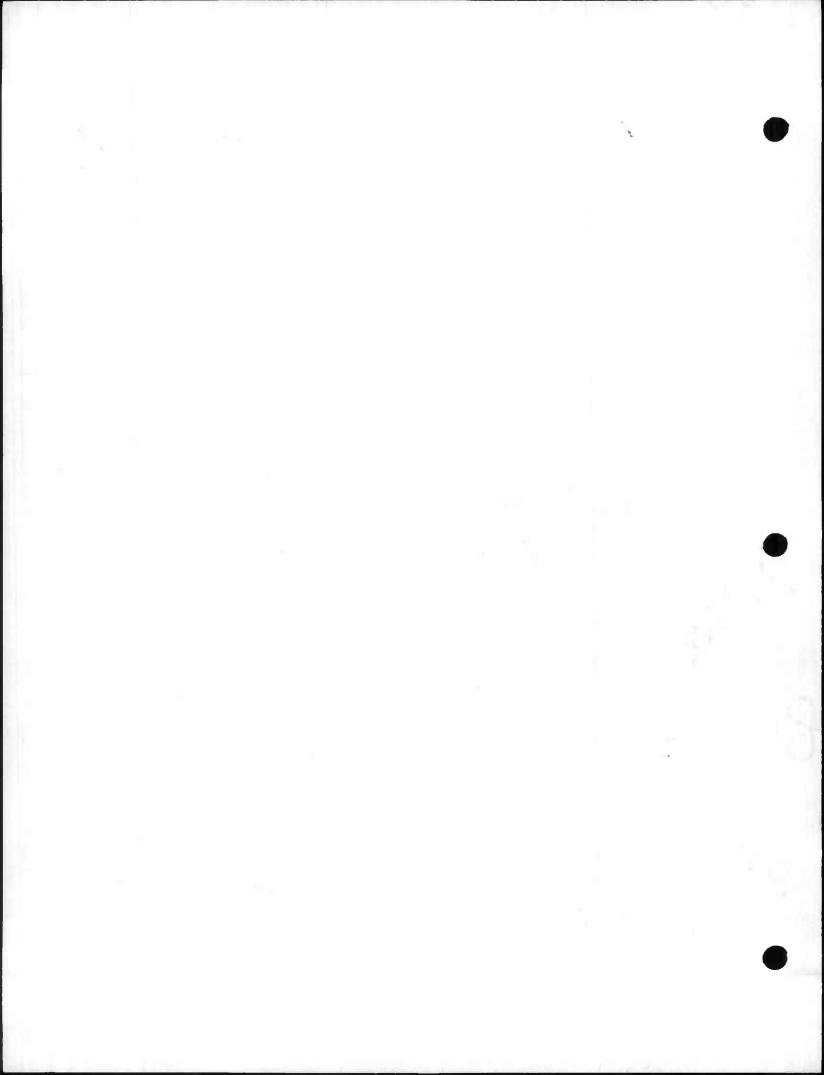
93 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH MONTH DAY 3. TIME OF OEATH

	AllCollio	Chappoti	-11						3	13		93	10Rm M							
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	t birthday)	IF UNDER		IF UNDER			OF BIRTH		8. BIRTHP	LACE (State or Foreign							
	267-80-2644	1 📉 M 2 🗀 F	52	YRS.	MONTHS	DAYS	HOURS	MIN.		th, Day, Year) -11-194		Country								
	9e. FACILITY NAME (If not institution, give s	treet and number)	3 -		9h CITY	TOWN O	R LOCATIO	W OF DE		-11-194		Cut								
Œ					0.00				AIII		9c. C001	NIT OF DE	AIR							
2	12825 Valleywood	Drive			Sil	ver	Spri	ng			Mo	ntgon	nery							
낊	10a. STATE 10b. COUNTY	r		10c CIT	Y, TOWN O	P LOCAT	ION													
E.													10d. INSIDE CITY LIMITS?							
	Maryland Mont	S	ilve	r Sp	ring						YES 2 NO									
₹	10e. STREET AND NUMBER					101.	ZIP CODE				10g. CITI	ZEN OF WH	IAT COUNTRY?							
E	12825 Valleywoo			20902	2			C	uba											
FUNERAL DIRECTOR	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED			13. V	13. WAS DECENDENT OF HISPANIC ORIGIN? (Speci			N? (Specify Yes											
F	1 - Never Married 2 X Married	FORCES? 1 YES 2 NO			1	If yes, specify Cuben, Mexican, Puerto Ricar			Rican, etc.)	I Line See	Black,	White, etc.								
ВУ	3 Widowed 4 Divorced	3 13 13 13 13 13 13 13 13 13 13 13 13 13			1 '	1 △ YES 2 ☐ NO Specify:				an	1	Specify	White							
COMPLETED	15. DECEDENT'S EQU	CATION	16a. DE	CEDENT'S	USUAL OC	CUPATIO	N .			b. KINO OF BU	SINESS/INC		MILLE							
E	(Specify only highest grade		(Gi	ve kind of a	work done o	during mos	st of working	7		DE AUTO OF DO	5114E557114E	rosini								
7	Elementary/Secondary (0-12)	College (1-4 or 5+)					on Corker		ny	Const	ruct	ion I	ndustry							
Ξ		U	Con	stru	CLIO	n wo	r-													
8	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	ER'S NAM	WE (First,	Middle, Maiden	Sumeme)									
B	Antonio Chappo	tin					l A	Aida		Hart	У									
	19a. INFORMANT'S NAME (Type/Print)		19b	. MAILING	ADDRESS	(Street ar	nd Number o	or Rural A	oute Num	ber, City or Tow	n, Stete, Zip	Code)								
6	Eloisa Chappot	in	_	1282	5 Va	11ev	boow	Dri	VP. S	Silvers	Sprin	o M T	. 20902							
	20a. METHOD OF DISPOSITION		20b. PLACE A					<i>D</i> 11		E 20c. LO	-									
	1 Buriel 2 Cremation 3 Rame 4 Donation 5 Other (Specify)	oval from Stata	cemetery, crer	natory or o	ther place)	- 0-			2 1.0	200.20	1	City or low	ng, M.D.							
- 1	21. SIGNATURE OF FUNERAL SERVICE LIC	ENGEC	Gate	01 H	eaver	n ce	meter D ADORES	с у	3 <u>- 1</u> 5	1-93 81	Liver	Sprin	ig,M.D.							
	an ordinarione of fortening services are	7/								eral H	omo		20904							
	11/5	Mar -			11	800	NewH	lamps	shir	e Ave.	Silve	erSpr	ing,M.D.							
	23. PART I. Enter the diseases, or o	complications that	caused the dea	ath. Do r																
	shock, or heart fellure.	List only one caus	e on each line.		iot amai	tria inoc	aa or ayn	ig, accii	as can	diac of resp.	iratory str	est,	Approximata Interval Between							
	IMMEDIATE CAUSE (Final				0	6.							Onset and Death							
	disesse or condition resulting in death)	Conc	mo	No	40	2	2						3 mo							
		OUE TO (	OR AS A CONSEC	UENCE O	F): /	0														
z	Sequentially list conditions, a Corcumon of Jung										2 000									
은	Sequentially list conditions, If any, leading to immediate	OR AS A CONSEC	UENCE O	P):	·	1						13/100								
- I	cause. Enter UNDERLYING																			
Guese. Enter UNDERLYING													+							
IFICA	CAUSE (Disease or Injury that initiated events	DUE TO (	that Initiated events  DUE TO (OR AS A CONSEQUENCE OF):																	
RTIFICA	CAUSE (Disease or Injury	DUE TO (	OR AS A CONSEC	UENCE O	F):					resulting in death) LAST										
CERTIFICA	CAUSE (Disease or injury that initiated events resulting in death) LAST	d																		
AL CERTIFICATION	CAUSE (Disease or Injury that initiated events	d				derlying	cause gi	ven in F	Part I.	24s, WAS AN			VERE AUTOPSY FINDINGS							
	CAUSE (Disease or injury that initiated events resulting in death) LAST	d				derlylng	cause gl	ven in F	Part I.	PERFOR	IMED?	1	WERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE							
	CAUSE (Disease or injury that initiated events resulting in death) LAST	d				deriying	) cause gl	ven in f	Part I.		IMED?	1 6	WAILABLE PRIOR TO							
MEDICAL	CAUSE (Disease or injury that initiated events resulting in death) LAST	d				derlying	) cause gi	ven in F	Part I.	PERFOR	IMED?	0	WAILABLE PRIOR TO COMPLETION OF CAUSE							
MEDICAL	CAUSE (Disease or injury that initiated events resulting in death) LAST	d				derlying	) cause gl	ven in F	Part I.	PERFOR	IMED?	0	WAILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH?							
AN: MEDICAL	CAUSE (Disease or injury that initiated events resulting in death) LAST	s contributing to d			In the und	26. PL	) cause gl			PERFOR	IMED?	0	WAILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH?							
AN: MEDICAL	CAUSE (Disease or Injury that Initiated events resulting in death) LAST  PART II. Other significant condition  25. WAS CASE REFERRED TO MEDICAL	d	Seath but not re	esulting of	In the und	26. PLJ		ATH (Che	ck only o	PERFOF  1 YES 2	IMED?	0	WAILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH?							
AN: MEDICAL	CAUSE (Disease or Injury that Initiated events resulting in death) LAST  PART II. Other significant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL: 1   Inpetient 2   28e. DATE OF II	Seath but not re	DOA 28b. TIM	OTHER 4   Nurs	26. PL/lt:	ACE OF DE	ATH (Che	ck only or	PERFOF  1 YES 2	IMED?	1	WAILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH?							
PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that Initiated events resulting in death) LAST  PART II. Other significant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	HOSPITAL:	Seath but not re	DOA 28b. TIM	OTHER	26. PL/ t: sing Home 28c. INJU WOF	ACE OF DE	ATH (Checklence t	ck only or	PERFOR  1  YES 2  ne)	IMED?	1	WAILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH?							
BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that Initiated events resulting in death) LAST  PART II. Other significant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	HOSPITAL: 1   Inpetient 2   28s. DATE OF II	ER/Outpatient 3 NJURY	DOA 28b. TIM	OTHER 4 Nuns	26. PLJ ing Home 28c. INJU WOF 1   Y	ACE OF DE	ATH (Checklence t	ck only or	PERFOR  1 YES 2  The Performance of the Performance	NJURY OCC	CURED	WAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH?							
BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that Initiated events resulting in death) LAST  PART II. Other significant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 VES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending	HOSPITAL: 1 Inpetient 2 Logical Month, Day 28s. PLACE OF	Seath but not re	DOA 28b. TIM	OTHER 4 Nuns	26. PLJ ing Home 28c. INJU WOF 1   Y	ACE OF DE	ATH (Checklence t	ck only or	PERFOR  1  YES 2  ne)	NJURY OCC	CURED	WAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH?							
BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that Initiated events resulting in death) LAST  PART II. Other significant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2  MO  27. MANNER OF DEATH  1  Netural 5  Pending Investigation  2  Accident Investigation  3  Suicide 8  Could not be detarmined	HOSPITAL: 1 Inpetient 2 Logical Month, Day 28s. PLACE OF	ER/Outpatient 3  NJURY (, 'b'ar')	DOA 28b. TIM	OTHER 4 Nuns	26. PLJ ing Home 28c. INJU WOF 1   Y	ACE OF DE	ATH (Checklence t	ck only or	PERFOR  1 YES 2  Per (Specify)  SCRIBE HOW IN  CATION (Street is	NJURY OCC	CURED	WAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH?							
BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that Initiated events resulting in death) LAST  PART II. Other significant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	HOSPITAL: 1 Inpetient 2 Information (Month, Day) 28s. PLACE OF	ER/Outpetlent 3 NJURY (x Year) INJURY — At hone, (Specify)	DOA 28b. TIM	OTHER 4   Nurs E OF URY M	26. PLJ: ing Home 28c. INJU WOF 1  Yory, office	ACE OF DE  5 TRes  JRY AT  RK?  ES 2	ATH (Checkledence &	ck only or other 28d. DES	PERFOR  1 YES 2  Per (Specify)  SCRIBE HOW IN  CATION (Street is or Yown, State)	NJURY OCC	CURED or Rural Roll	WAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH?							
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BE COMPLETED BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that Initiated events resulting in death) LAST  PART II. Other significant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation 3 Suicide 8 Could not be distarmined  29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER  29b. SIGNATURE AND TITLE OF CERTIFIER  2 Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y	HOSPITAL: 1   Inpetient 2   28a. DATE OF II (Month, Day) 28a. PLACE OF building, et	ER/Outpatient 3  NJURY — At hone to company knowledge, dealermination and/or in the company knowledge of the company know	DOA 28b. TIM INJ	OTHER 4   Nurs E OF URY M street, factor of at the tire, in my op	26. PLJ i: iling Home 28c. INJU WOF 1  YOF, office me, data a pinion, de	ACE OF DE	ATH (Check to NO NO NO NO NO NO NO NO NO NO NO NO NO	ck only or other 28d. DE:	PERFOR  1 YES 2  Per (Specify)  SCRIBE HOW IN  CATION (Street is or lown, State)	NJURY OCC	or Rural Roll ad. e couse(a) a	WAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH?  YES 2 NO  When Number,  and menner as stated,							



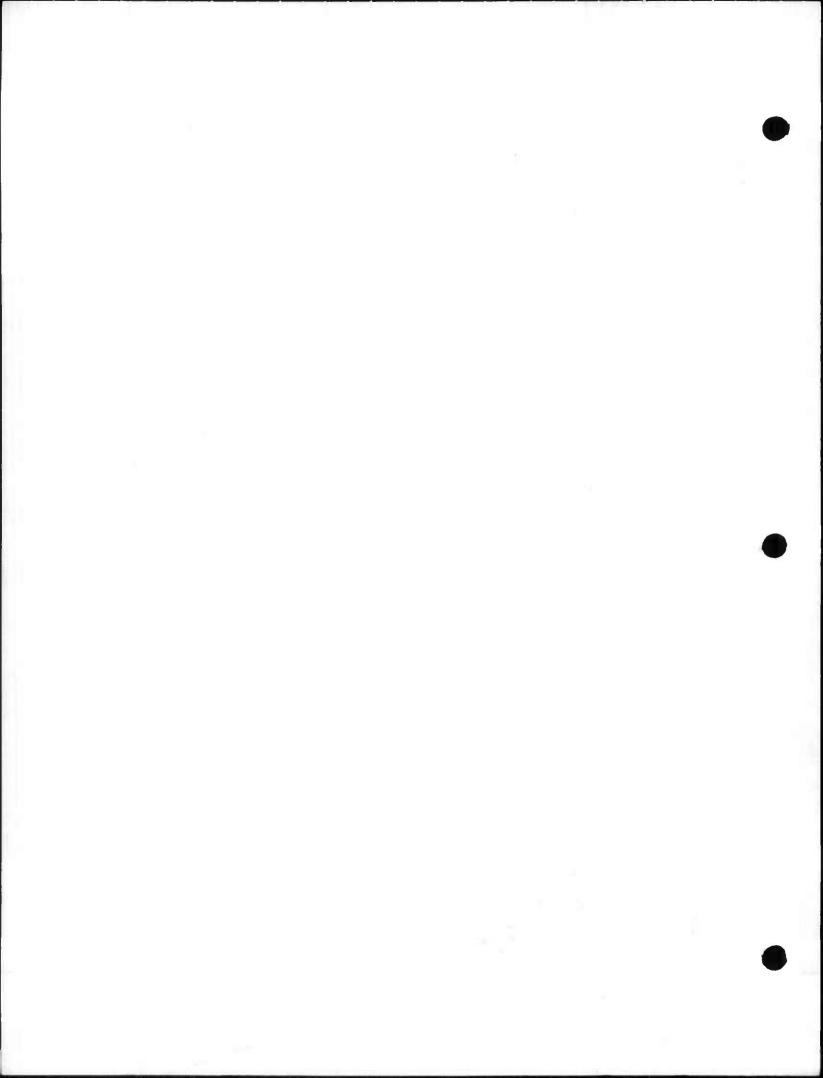
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THE MILE OF THE PRINCIPLY THE INTERPRETATION THE INTERPRETATION OF THE OFFICE OF THE PROPERTY	8	the filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: Il item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARYLA		MENT OF H		MENTAL HYGIEN	_	93 09666		
	1. DECEDENT'S NAME_(First, Middle, Last)	EDE GARORALE	mmr			2. DATE OF DEATH MONTH	MY YE	3. TIME OF DEATH		
	ALB	SERT CAPORALE		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	-73	BIRTHPLACE (State or Foreign		
- 1	577-20- 2897	1 km 2 □ F 72	***	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) 3-31-1920	W	ash. D.C.		
	9a. FACILITY NAME (If not institution, give a	treet and number)			OR LOCATION OF D		9c. COUNTY			
OT	8103 17th Place			Adelp	hi		Prince	e George		
DIRECTOR	Maryland Princ	v ce George	10c. CITY, Adel:	TOWN OR LOCAT	TION			10d. INSIDE CITY LIMITS?		
	10e. STREET AND NUMBER				. ZIP CODE		10g. CITIZEN	1 🖾 YES 2 🗌 NO OF WHAT COUNTRY?		
FUNERAL	8103 17th Place			20783			USA			
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	J.S. ARMEO 2 NO ES	If yes, sp	ENDENT OF HISPA ecity Cuban, Mexic 25 NO Speci	NIC ORIGIN? (Specify Yean, Puerto Rican, etc.) ly:	s or No- 14.	RACE — American Indian, Black, White, etc. Soewhite			
TED	15. DECEDENT'S EDU (Specify only highest grade	completed)	(Give kind of wo	rik done during mo	ON st of working	16b. KIND OF BU	SINESS/INDUST	RY		
Caprestry Only Impress grade Completed)   Gife kind of work done during most of working   He. Do NOT use retried.)   Supervisor   Western Electric   Tr. FATHER'S NAME (First, Middle, Last)   Is. MOTHER'S NAME (First, Middle, Maiden Surname)										
CON	17. FATHER'S NAME (First, Middle, Last)	- 120				AME (First, Middle, Maider	Sumame)			
8	Attilio Caporalet  19a, INFORMANT'S NAME (Type/Print)	tti	195 MAII ING A		Stella D	DiPierro  Aoute Number, City or Tow	- C 7'- C			
2	Michael J. Capor	aletti								
	20s. METHOD OF DISPOSITION  20b. PLACE AND DATE OF OISPOSITION (Name of OATE 20c. LOCATION — City or Town, State									
	1 St Burisi 2   Cremation 3   Removal from State   Competery, crematory or other place   Gate of Heaven   3/19/93   Silver Spring, Md.									
	22. NAME AND AGORESS OF FACILITY HINES-RINALDI FUNERAL HOME 11800 New Hampshire Ave. Silver Spring, M									
ERTIFICATION	23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  OUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):									
N: MEDICAL C	PART II. Other algorificant condition (Told), Myo	ne contributing to death but	g cause given in	Part I. 24a. WAS AN PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2 NO				
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PI	ACE OF DEATH (C	heck only one)				
PHYSICIAN:	PH YES 2 □ NO. 27. MANNER OF DEATH	1 Inpatient 2 ER/Outpat		□ Nursing Horr		8 Other (Specify) 28d. OESCRIBE HOW	IN HIRY OCCUR	FO		
ву Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU	RY WO	PRK? YES 2 NO					
8	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — building, atc. (Specify	- At home, larm, str	reet, factory, offic		281. LOCATION (Street City or Town, State	and Number or F )	Rural Floute Number,		
COMPLET		ICIAN: To the best of my knowled						ouse(s) and menner as stated.		
BE C	286. SIGNATURE AND TITLE OF DESTREET	7	m		29c. LICENSE NU	MBER	29d. DATE SI	GNED (Month, Day, Year)		
5	30, HAME AND ADDRESS OF PERSON WH	HO COMPLETED CAUSE OF DEAT	H (ITEM 27) (7509)	pind 1	N1 .	30	1-2-	12-43		
	31. DATE FILED MOVIE, Days May 1	12 ABQUETRANT'S SIGNAT		ayher	1 Ct	1000-11	170	748		
	L. 00	0								



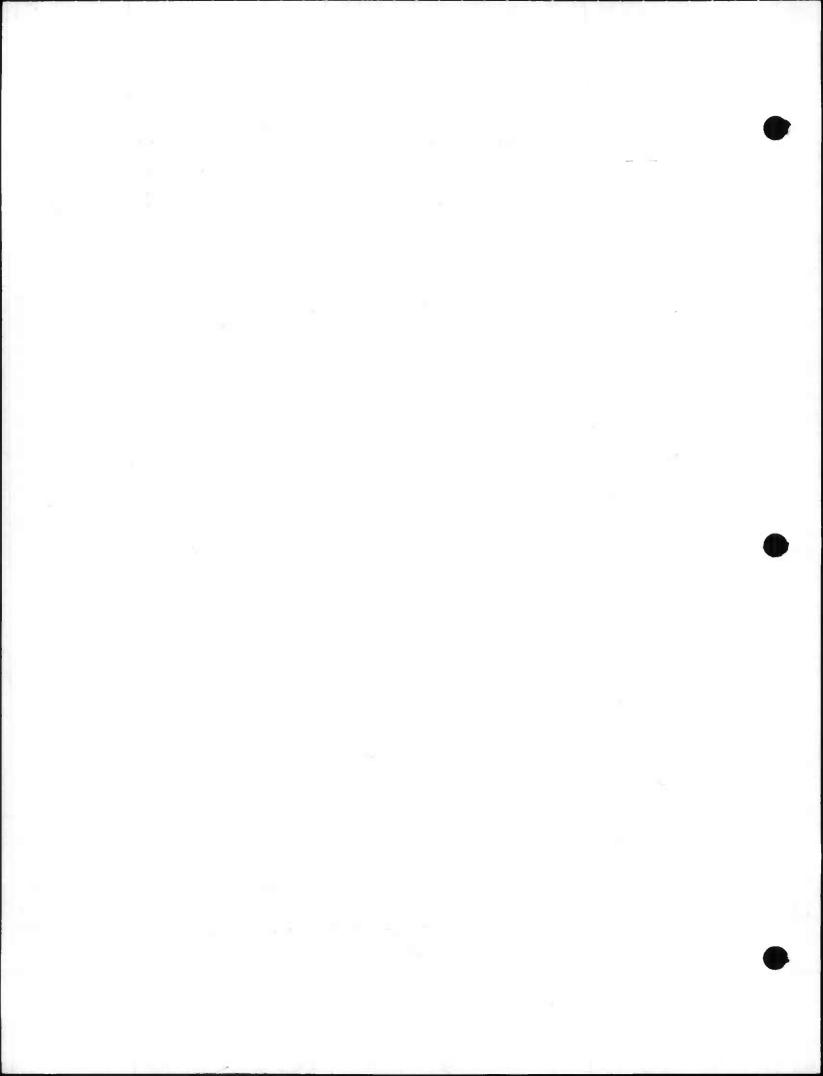
	nes 1, 2, 3 should	
ding physician.	the burial-transit permit. P.	
ed by the hospital or atten	ild be detached for use as	
th. Page 6 may be retained	by the funeral director, page 5 shou	
e executed within 24 hours after death. Page 6 may b	pletely filled in by the fur	remation, or removal.
certificate be executed	nding physician and com	Hygiene prior to burial,
AN: The law requires that the death certificate be e	been signed by the atter	it. of Health and Mental Hygi
IG PHYSICI	After this certificate has	death with the State Dep
AL DR ATTENDIN	A DIRECTOR:	72 hours after

		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	RTMENT OF I	HEALTH AND	MENTAL HYGIEN		0 0 0 0 7
	- 1	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
			Maybelle P.				March 21		1:00 Pm
99		4. SOCIAL SECURITY NUMBER 579-28-7927		In yrs. lest birthday)	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Morth, Day, Year) Oct.9, 19		BIRTHPLACE (State or Foreign Country)  Maryland
physician. burial-transit permit. Pages 1, 2, 3 should	OR		street and number)			on Location of Di Bethesda	EATH	9c. COUNTY MOT	of DEATH itgomery
- SS	DIRECTOR	RESIDENCE OF DECEDENT  10a, STATE  10b, COUNT	Υ	10c. CI	TY, TOWN OR LOCA	TION			10d. INSIDE CITY
mit. Pag		Maryland	Montgomery		В	ethesda			LIMITS?
an. ransit pe	FUNERAL	10003 Edward Ave	nue		10	f, ZIP CODE	814		of what country? ed States
or attending physician. r use as the burial-tran	ВУ	11. MARITAL STATUS 1 Never Married 2 Married 2 Married 3 Married 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	If yes, s		NIC ORIGIN? (Specify Yen, Puerto Rican, etc.)	s or No 14.	RACE — American Indian, Black, White, etc. Specify: White
the hospital or attending detached for use as the once.	COMPLETED	15. DECEDENT'S EDL (Specify only highest grade Elementary/Secondary (0-12)			USUAL OCCUPATE work done during misse retired.)		16b. KIND OF BU	SINESS/INDUST	RY
the hospital detached fo		12		Home	emaker		C	wn Home	е
	00	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maider	Surname)	
5 should be	H	Aloysius Padgett  190. INFORMANT'S NAME (Type/Print)		405 404 1111			Winslow		
s retained 5 should notlilled	2	Bobby J. Richter:	S				Route Number, City or Tow ethesda, M		
ray be		20g METHOD OF DISPOSITION 1 Burlal 2 Cremetion 3 Ren	206.	PLACE AND DATE	OF DISPOSITION (N	ame of		CATION — City	
ige 6 ma Strector, p		4 Donation 5 Other (Specify)	C	edar HiI	I Cemete				Maryland
hours after death. Page 6 may ed in by the funeral director, pa or removal. medical examiner must b		21, SIGNATURE OF FUNERAL SERVICE LI	//	) M00672	Home/ Wisco 3501	ND ADDRESS OF FA Bethesda nsin Ave	Chevy Chanue, Bethe	A. Pum se, In sda, M	phrey Funeral 2557 aryland 20814-
hat the death certificate be executed within 24 hours after d by the attending physician and completely filled in by the and Mental Hyglene prior to burial, cremation, or removal ny injury, or other traumatic event, the medical	CERTIFICATION	23. PART I. Enter the diseases, or shock, or heart failure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	Elist only one cause on et  Congestive  DUE TO (OR AS A  COTONARY A  DUE TO (OR AS A  C.  DUE TO (OR AS A	Heart 1 consequence of the conse	Failure Pn: clerotic			eratory arrest,	Approximata interval Between Onset and Death  1 Hour  5 Years
w requires that the dea to be signed by the att pt. of Health and Menta shows any Injury,	MEDICAL C	PART II. Other significant condition	ns contributing to deeth be	ut not resulting	in the underlyin	g cause given in	Part I. 24a, WAS AF PERFO	RMED?	24b. WER AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
has b Dept.	AN	25. WAS CASE REFERRED TO MEDICAL			26. P	LACE OF DEATH (Ch	eck only one)		
SICIAN: The certificate h the State d, or item	PHYSICIAN	EXAMINER? 1   YES 2 □ NO	HOSPITAL: 1   Inpatient 2   ER/Outp.	etlent 3 DOA	OTHER:	ne 5XXResidence			
NG PHYSICI fler this cer sath with th marked, o	E	27. MANNER OF DEATH  1XXNetural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIN	JURY W	JURY AT ORK?	28d. DESCRIBE HOW	INJURY OCCUR	:D
DR ATTENDING PHYSICIAN: The law FUNECTOR: After this certificate has b hours after death with the State Dept. Item 28 is marked, or item 23	ED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide detarmined	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm,		YES 2 NO	281. LOCATION (Street City or Town, State		tural Route Number,
DR AT DIRECT hours a	<b>L</b>	20a CERTIFIER					-2	a measure	
4 200 =	COMPL	and a	ICIAN: To the best of my knowl						use(a) and manner as stated.
TO THE HOSPITA TO THE FUNERA DE filed WIDNIN-T IMPORTANT:	BE (	246. SIGNATURE AND TITLE OF CORRECT	Malla	M	10	29c. LICENSE NUI			Ch 22, 1993
₽₽₩.	2	JOSOPH T Walla				D11031		1	
		31. DATE FILED (Month), Day, Year)		M.D., 5272 River Road, #340, Bethesda, Maryland 20816  32. REGISTRADES SIGNATURE  June Davidson Maryland 20816					



BALTIMORE, MARYLAND 21215	24 hours after death. Page 6 may be retained by the hospital or atten-	y filled in by the funeral director, page 5 should be detached for use as	the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	THE MOSTING OF ATTENDING PRINCIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending	TO WE THINED. CHRECTURE Are the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as	INPORTANT. If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FIDNA M. CHARLTON FOR STATE OF MARYLAN  1 - REGISTRAR	D / DEPARTMENT CERTIFICATE				00000			
1	1. DECEDENT'S NAME (First, Mirkelle, Last)	M. CH	ARITON	REG. NO  2. DATE OF DEATH MONTH D	YEAR	3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yr 1 ☐ M 2 🖾 F 96	rs. lest birthday) IF UNDER 1 YRS. MONTHS	YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) FEB. 13, 18	A BIR	THPLACE (State or Foreign noty) LINOIS			
TOR	98. FACILITY NAME (If not institution, give street and number)  WINN HEALT CALL CENTER  RESIDENCE OF DECEDENT	-   0	HANS been	ATH	8c. COUNTY OF DEATH  Montgonery				
DIRECTOR	MD. 100. COUNTY MONTGOMERY	10c. CITY, TOWN OF	LOCATION HERSEURG		10d. INSIDE CITY LIMITS?  1 XYES 2 N				
FUNERAL	301 RUSSELI, AVENUE		101. ZIP CODE 20877		10g. CITIZEN OF	WHAT COUNTRY?			
8	11. MARITAL STATUS  1 Never Married 2 Married  2 Wildowed 4 Divorced  12. WAS DECEDENT EVER IN U. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	! □NO If	AS DECENDENT OF HISPAN yes, specify Cuben, Mexicar YES 2 ND Specify	, Puerto Rican, etc.)	Ble	CE — American Indian, ack, White, etc. ecity:			
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	a. DECEDENT'S USUAL OC (Give kind of work done do life. Do NOT use retired.) HOMEMAKER	CUPATION uring most of working		SINESS/INDUSTRY	WALL IN			
	17. FATHER'S NAME (First, Middle, Last) SHERI)AN HOWER		and the second s	IE (First, Middle, Maiden		· · ·			
TO BE	190. INFORMANT'S NAME (Type/Print) DOLORES S. BURGESS	196. MAILING ADDRESS 9620 GLEN	(Street and Number or Rural R	oute Number, City or Tow	n, State, Zip Code)	20744			
20a. METHOD OF DISPOSITION 1 B Burlet 2 Cremetton 3 Removal from State 4 Donation 5 Other (Specify)  20b. PLACE AND DATE OF DISPOSITION (Name of Computing, cremetory, cremetory, cremetory place EMETERY  3/26 SUNSHINE, MD									
8	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  BUTH		AME AND ADDRESS OF FAC RIEL H. BARI 525 LAYTONS			20882 VILLE, MD.			
CERTIFICATION	23. PART i. Enter the diseases/ or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):								
MEDICAL	PART II. Other significant conditions contributing to death but r	not resulting in the und	erlying cause given in I	Part I. 24a. WAS AN PERFOR	MED?	4b. WERE AUTOPSY FINDINGS AMULABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL  EXAMINER?  1 YES 2 NO 1 Inpetient 2 ER/Outpetter	<b>ОТНЕ</b>		Service of the service of					
энх	27. MANNER OF DEATH 28a. DATE OF INJURY	1	ng Home 5 Residence ( RSc. INJURY AT WORK?	Other (Specify)  28d. DE\$CRIBE HOW I	NJURY OCCURED				
ED BY I	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be building, etc. (Specify)	М	1 YES 2 NO	28f. LOCATION (Street a City or Town, State)	and Number or Rura	I Route Number,			
COMPLETE	29s. CERTIFIER (Check only one)  2   MEDICAL EXAMINER: On the basis of examination an					e(a) and manner as stated.			
BE	296. SIGNATURE AND TITLE OF CENTIFIER	me	29c. LICENSE NUM			ED (Month, Day, Year)			
5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH		wisen	5	61-	Par Tank			
	31. DATE FILED (MONTH, Day, Hear) 32. REGISTBAR'S SIGNATU				6				



2. DATE OF DEATH DAY

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<b>BALTIMORE, MARYLAND 2121</b>	ecuted within 24 hours after death. Page 6 may be retained by the hospital or atte
Y	the state
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MAR	retained
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Σ	Page
AL	death.
m	after
	hours
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60,	within
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1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

31. DATE FILED (Month, Day, Year)
MAR 12 'C

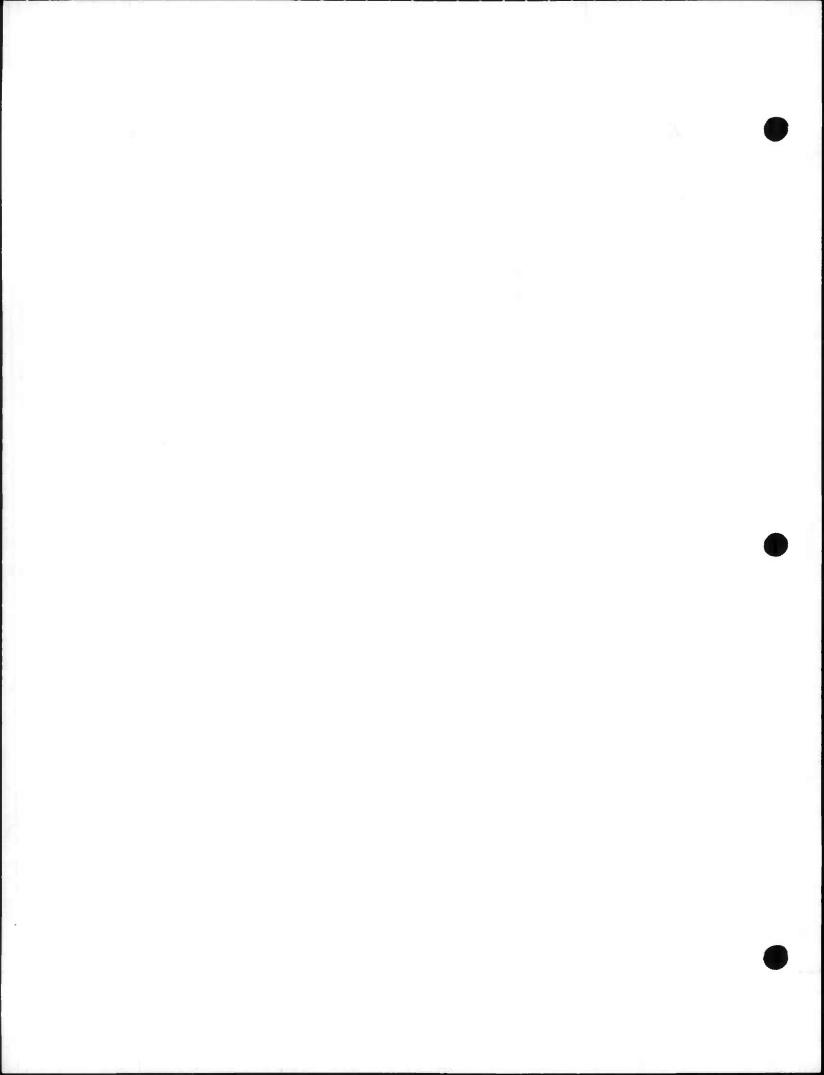
DIVISION OF VITAL RECORDS, P.O. BOX

ż		Harvey	B. Co	Hrey		Caffrey	MONTH 8		3 3:28 A
ъ		4. SOCIAL SECURITY NUMBER 579 - 03-612	5. SEX 1 M 2 [7 F		HTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country) ashington, D. C.
I, 2, 3 should	TOR	9a. FACILITY NAME (If not institution, gi	Hospita,	98	0.5	OR LOCATION OF DI	Ring	Sc. COUNT	of DEATH of GOMERN
permit. Pages 1,	DIRECTOR	MD MO	ntgom < R		hear				10d. INSIDE CITY LIMITS? U YES 2 NO
-55	FUNERAL	100. STREET AND NUMBER 11962 ANDREY	Val		1	Of ZIP CODE	2	1 -	N OF WHAT COUNTRY?
24 nours after death. Page 6 may be retained by the hospital or attending physician. filled in by the funeral director, page 5 should be detached for use as the burial-transit ion, or removal.	B	11. MARITAL STATUS 1 Never Married 2 Married 3 Nidowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES	2 X NO	If yes, s	CENDENT OF HISPAI pecify Cuban, Mexica S 2 X NO Specif	NIC ORIGIN? (Specify Years, Puerto Rican, etc.)	s or No 14	Black, White, atc. Specify: White
al or attend for use as	ETED	15. DECEDENT'S E (Specify only highest gr Elementary/Secondary (0-12)	rede completed)	16a. DECEDENT'S USI (Give kind of work life. Do NOT use re	done during m	ION lost of working	18b. KINO OF BU	SINESS/INDUS	
the hospital detached for once.	COMPL	12	College (1-4 or 5+)	Letter	Carri			_	Service
by the horbe detach	6 m	17. FATHER'S NAME (First, Middle, Last) Harvey B. Caffre	2 V			1	ME (First, Middle, Meider ed_McLear	Sumame)	
5 should	TO B	19a, INFORMANT'S NAME (Type/Print) Clara E. Caffre		196. MAILING AD	ORESS (Street	and Number or Rural	Route Number, City or Tox	vn, State, Zip Co	ode)
page :		20a. METHOD OF DISPOSITION	20	b. PLACE AND DATE OF D	DISPOSITION		DATE 200. L		9U.Z y or Town, State
director, p		1 \( \mathbb{Y}\) Burial 2 \( \text{Cremation} 3 \) \( \text{R}\) 4 \( \text{Donation} \) 5 \( \text{Other} \) (Specify) \( \text{CP}\) 21. SIGNATURE OF FUNERAL SERVICE	Fo	metery, crematory or other ort Lincolr	Ceme	tery 3/1	111/93	entwood	d,Maryland
ter death. Pag the funeral di oval.		· Denni	a a Capata	et .	11800	New Hamp	Hines- shire Ave	Silve	i Funeral Home er Spring,Md.
nted within 24 hours after completely filled in by the rial, cremation, or removal.		23. PART I. Enter the diseases, abook, or heart failure iMMEDIATE CAUSE (Final disease or condition resulting in death)	a. LIVER f  DUE TO (OR AS	each line.	enter the m	ode of dying, suc	h as cardiac or resp	iratory arres	t, Approximate interval Between Onset and Death
certificate be executing physician and Hygiene prior to but raumatific other traumatific reconstructions of the reconstruction of th	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	· CAKOINO	A CONSEQUENCE OF):	LON				
w requires that the death been signed by the atter pt. of Health and Mernal I shows any Injury, o	: MEDICAL	PART II. Other significant condit	lons contributing to death	but not resulting in the	he underlyir	ng cause given in	Part i. 24a. WAS AI PERFO 1 UYES	RMED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
rSician: The law certificate has the th the State Dept d, or Item 23	PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 N NO	HOSPITAL:		THER:	LACE OF DEATH (Ch			
五元至四		27. MANNER OF DEATH  1 🔀 Natural 5 🗌 Pending	11℃ Inpetient 2 ☐ ER/Out  28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	F 28c. IN	JURY AT ORK? YES 2 NO	6 Other (Specify)  28d. DESCRIBE HOW	INJURY OCCUP	RED
L OR ATTENDING P DIRECTOR: After the hours after death tem 28 is man	ETED BY	2 Accident threatigered 3 Suicide S Could not ( 4 Homicide determined	28e. PLACE OF INJUR building, etc. (Soe	Y — At home, farm, stree	et, factory, offi	ca	281. LOCATION (Street City or Town, State	and Number or	Rural Route Number,
로로	COMPLE		YSICIAN: To the best of my know						ause(a) and manner as stated.
F 45 8	BE	296, SIGNATURE AND TITLE OF CERTIFIC	FIER hards	-D		29c, LICENSE NUN			IGNED (Month, Day, Year)
9.1	٩	30. NAME AND ADDRESS OF PERSON		EATH (ITEM 27) (Type, Prin	nt)	P-12	, , , ,	, , ,	. ~

32. REGISTRAR'S SIGNATURE

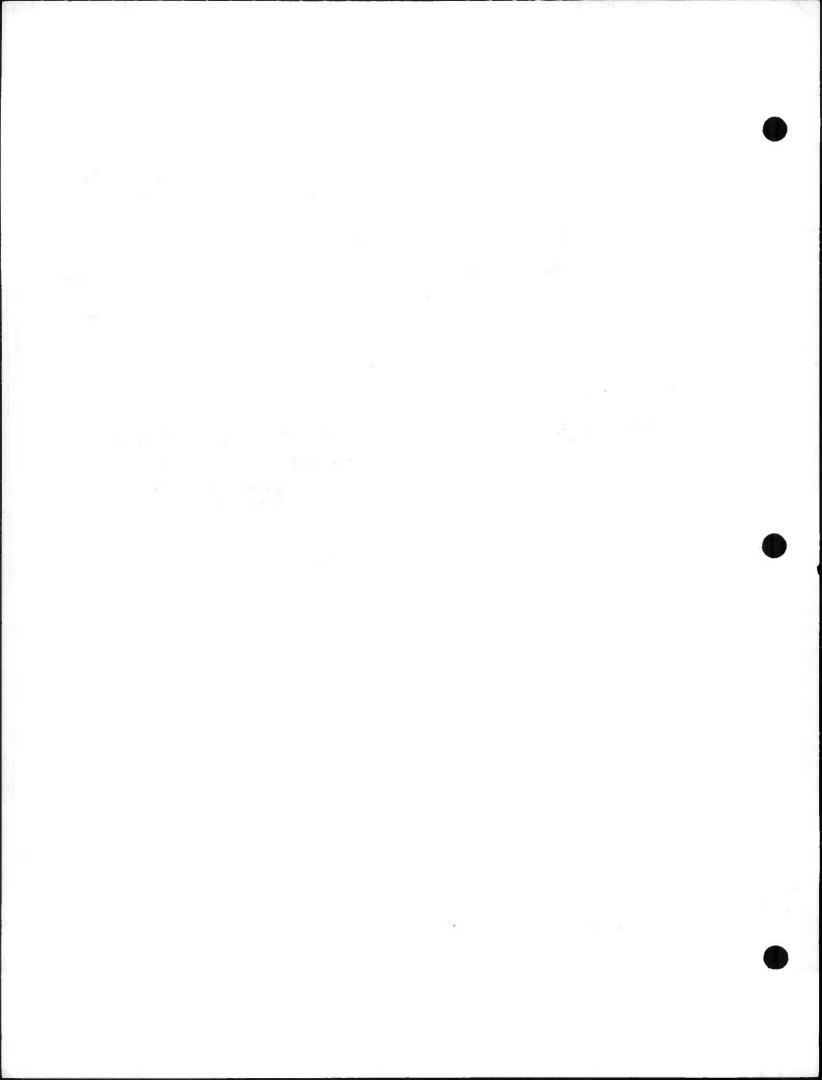
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

/ Harvey B. Caffrey



10s. STREET AND NUMBER 2600 Queens Chape	Took and number)  HOSPITAL  CE Georges  Road #301  12. WAS DECEDENT EVEN IF VES, GIVE WAR OR D	(In yrs. lest birth:  15 YR  10c.  N U.S. ARMED 2	9b. CTTCHE CHE CTY, TOWN Hyatts	OR LOCATE VER SVIT 1010 WAS DECEMBER 1 YES	IF UNDER 24 HRS. HOURS MIN. DR LOCATION OF DR L. Y  TION 1 e  2. ZIP CODE 20782  EENDENT OF HISPA ecity Cuban, Maxic: 2 X NO Specifical	7. DATE (Mon	OF BIRTH th, Dey. Year)  YIJA YV	1978 B. 14. PRINCE PRINCE Unit	BIRCL While, etc.
579-08-2818  9a. FACILITY NAME (If not Institution, give str PRINCE GEORGES  RESIDENCE OF DECEDENT  10a. STATE MD.  10b. COUNTY Princ  10c. STREET AND NUMBER 2600 Queens Chape  11. MARITAL STATUS  14. Never Married 2 Married 3 Widowed 4 Divorced  15. DECEDENT'S EDUC. (Specify only highest grade of the county	1 M 2 Q F  seet and number)  HOSPITAL  CE Georges  Road #301  12. WAS DECEDENT EVEN IF VES, GIVE WAR OR D  ATION completed)	N U.S. ARMED 2 ⊠ NO ATES  18a. DECEDER (Give kinc. iiie. Do No	9b. CIT'CHE CATY, TOWN Hyatts  13.	DAYS  Y, TOWN C  EVER  OR LOCAT  SV1 1  104  WAS DEC. If yes, sp 1  YES	HOURS MIN.  OR LOCATION OF D  L Y  TION  1 E  2 0 7 8 2  ENDENT OF HISPA ecity Cuban, Maxica 2 N NO Specifican	NIC ORIGI	N? (Specify Yes	1978 14 9c. COUNTY PRINC 10g. CITIZE Unit	Washington of Death CE GEORG  10d. INSIDE LIMITS? 1 X YES 2 N OF WHAT COUNTR ed States 1. RACE - American Black, White, stc. Specify: Black
PRINCE GEORGES  RESIDENCE OF DECEDENT  108. STATE MD.  109. STREET AND NUMBER 2600 Queens Chape  11. MARITAL STATUS 1. Never Married 2 Married 3 Widowed 4 Divorced  15. DECEDENT'S EDUC. (Specify only highest grade of State of St	HOSPITAL  Ce Georges  Road #301  12. WAS DECEDENT EVEN IF ORCES? 1 1 VES IF YES, GIVE WAR OR D  ATION completed)	N U.S. ARMED 2   NO NO NTES  16a. DECEDEN (Give kinc.	CHE CTY, TOWN Hyatts  13.	OR LOCATOR TO THE PROPERTY OF	PLY  TION  1 e  1. ZIP CODE  20782  ENDENT OF HISPA ecity Cuban, Maxica 2 NO Specifican	NIC ORIGI in, Puerto y:	N7 (Specify Yes Rican, etc.)	9c. COUNTY PRINC	Y OF DEATH  CE GEORC  10d. INSIDE 1 X YES 2 N OF WHAT COUNTR ed States Black, White, stc.  Specify: Black
10e. STATE MD.  10e. STREET AND NUMBER 2600 Queens Chape  11. MARITAL STATUS 1. Never Married 2 Married 3 Widowed 4 Divorced  15. DECEDENT'S EDUC (Specify only highest grade of Pth  17. FATHER'S NAME (First, Middle, Last) Gregory Campfield  19e. INFORMANT'S NAME (Type/Print)	Road #301  12. WAS DECEDENT EVER I FORCES? 1 YES, GIVE WAR OR D  ATION Completed)	N U.S. ARMED 2   NO NOTES  16a. DECEDER (Give kinc.	Hyatts  13.  NT's USUAL Of of work done of use retired.)	WAS DEC If yes, sp 1 YES	TENDENT OF HISPA ecity Cuban, Maxica 2 NO Specifican	in, Puarto y:	Rican, etc.)	Unit	I MITS?  1 X YES 2  N OF WHAT COUNTR  ed States  1. RACE — American Black, Whita, atc.  Specify: Black
10e. STREET AND NUMBER 2600 QUEENS Chape  11. MARITAL STATUS 1. Never Martied 2 Married 3 Widowed 4 Divorced  15. DECEDENT'S EDUC. (Specify only highest grade of Pth  17. FATHER'S NAME (First, Middle, Last) Gregory Campfield  19e. INFORMANT'S NAME (Type/Print)	Road #301  12. WAS DECEDENT EVER I FORCES? 1 YES, GIVE WAR OR D  ATION Completed)	N U.S. ARMED 2 X NO ATES  16a. DECEDEN (Give kine, Do No	NT'S USUAL Of of work done Of use retired.)	WAS DEC If yes, sp 1 YES	20782 ENDENT OF HISPA ecity Cuban, Mexica 2 \( \overline{\text{NO}} \) NO Specifical	in, Puarto y:	Rican, etc.)	Unit	n of what countried States I. RACE — American Black, White, etc. Specify: Black
1. Never Married 2 Married 3 Widowed 4 Divorced  15. DECEDENT'S EDUC. (Specify only highest grade of Pth 1971)  17. FATHER'S NAME (First, Middle, Last) Gregory Campfield  19a. INFORMANT'S NAME (Type/Print)	FORCES? 1 YES IF YES, GIVE WAR OR D  ATION completed)	2 NO ATES  16a. DECEDEN (Give kinc. iife. Do NO	NT'S USUAL Of of work done OT use retired.)	If yes, sp 1 YES	ENDENT OF HISPA ecity Cuban, Mexics 2 NO Special	in, Puarto y:	Rican, etc.)	or No — 14	Black, White, etc. Specify: Black
(Specify only highest grade of Pth 9th 9th 9th 9th 17. FATHER'S NAME (First, Middle, Last) Gregory Campfield 19a. INFORMANT'S NAME (Type/Print)	completed)	(Give kind life. Do NO	d of work done OT use retired.)	during mo	ON set of working	161	b. KIND OF BUS	SINESS/INDUS	-
17. FATHER'S NAME (First, Middle, Last) Gregory Campfield 19a. INFORMANT'S NAME (Type/Print)			Studen		•	- 1			
				nt	18. MOTHER'S NA		Middle, Maiden Jenkins		
Conchita Campfield		19b. MAII	LING AODRES	S (Street a	nd Number or Rural				ode)
20s. METHOD OF DISPOSITION	201	260	00 Que	ns C	Chapel Ro	OAT	yattsv	rille CATION — CH	Md 2078
4 Donation 5 Other (Specify)	H	armony	Nemor place)	ial	Park		la	ndovo	r Md
_		•	²Ř	NAME AN	Horton	CO.	Mortic	ians,	Inc.
IMMEDIATE CAUSE (Final	let only one cause on a	ach lina.	Do not antai	r tha mo	da of dying, auc				t, Approinterva
Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									
PART II. Other algnificant conditions	contributing to death b	out not reaulti	ing in the ur	nderlying	g cause given in	Part I.	PERFOR	MEO?	24b. WERE AUTOPS MAILABLE PR COMPLETION OF DEATH?  1  YES 2
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHE		ACE OF DEATH (Ch	eck only o	ne)		
1X YES 2 NO  27. MANNER OF DEATH	1 Inpatient 2 X ER/Outp		A 4 Nur	rsing Home				HIPV OCCUE	250
1 Natural S Pending 2 Accident Investigation		12	:40A	WO	PIC?				
3 Suicide 8 Could not be determined	28s. PLACE OF INJURY building, etc. (Spec	H(y)				City	or Town, State)		Rural Route Number,
									ause(a) and manner a
29b. STATURE AND TITLE OF CERTIFIER	hell								IGNEO (Month, Day, Ya
3	23. PART I. Entar tha diseases, or conshock, or heart failure. Limited in the conditions of the condit	A Buriel 2 Cremetton 3 Removal from State 4 Donetton 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. PART I. Entar tha diseases, or complications that caused the death. shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING c.  CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENC CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENC CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENC CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENC CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENC CAUSE (DISEASE OF INJURY CAUSE OF INJURY CAUSE OF INJURY CAUSE OF INJURY CAUSE OF INJURY CAUSE OF INJURY At home, feed tearmined cause. Cause of injury that injury cause injury cause of the could not be determined cause of injury cause of the could not be determined cause of injury cause of	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. PART I. Entar tha diseases, or complications that caused the death. Do not anta shock, or heart failure. List only one cause on each line.	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AN R. N. N. N. Short of Subscription and Subscription an	Donation   S Other (Specify)   Charles   Dark   Park	Donation   S   Other (Specify)   Charles   C	23. PART I. Enfar the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory of	All Donation S of Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LICENSEE  All Donation S of Other (Specify)  22. NAME AND ADDRESS OF FACILITY  R. N. HOrton Co. Morticians, 600 Kennedy Street, N. W.  23. PART I. Entar tha diseases, or complications that caused tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arreas shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final diseases or complications that caused the daath. Do not antar tha mode of dying, such as cardiac or respiratory arreas shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final diseases or condition resulting in death)  As Equantially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUEN

Aha Tavidous Randell



3. TIME OF DEATN

8:10

DHMH-16 Rev 1/89

2. DATE OF DEATH

MARCH

20

YEAR 1993

FOR STATE REGISTRAR 1 -1. DECEDENT'S NAME (First, Middle, Last)

ANNA

4. SOCIAL SECURITY NUMBER

LEE

5. SEX

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

IF UNDER 1 YEAR IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN.

CAVALIERE

8. AGE (In yrs. last birthday)

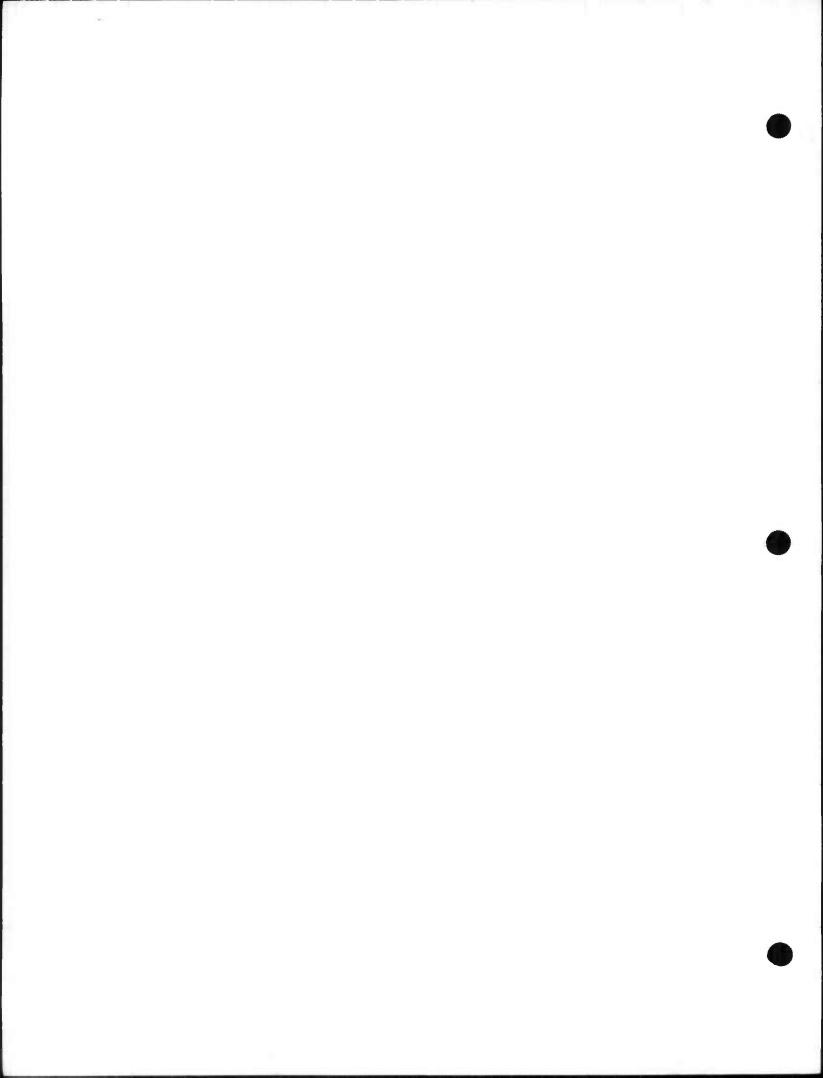
TO BE COMPLETED BY FUNERAL DIBECTOR IMPORTANT, If them 28 is marked, or flem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOWING DRIVINIONS PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed without 2 must at the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**DIVISION OF VITAL RECORDS, P.O. BOX 68760,** 

BALTIMORE, MARYLAND 21215-0020

-1	4. SOCIAL SECURITY NUMBER	5. SEX	B. AGE (In yrs. las	t birthday)	IF UNDER		IF UNDER		7. DATE OF (Month, D			a. BIRTNPL	NCE (State or Foreign
	578-26-2740	1 M 2 K F	85	YRS.	MONTHS	DAYS	HOURS	MIN.	NOV.	21,	1907	VIRG	INIA
	9e. FACILITY NAME (If not institution, give st	reet and number)			9b. CITY	, TOWN C	R LOCATI	ON OF OE	ATN		9c. COU	INTY OF DEAT	N ·
5	CIRCLE MANOR NU	RSING HO	ME		KE	NSI	IGTON	Ī			MON	NTGOME	RY
	RESIDENCE OF DECEDENT  10a, STATE 10b, COUNTY	,											
					Y, TOWN C							10-	d. INSIDE CITY LIMITS?
	MARYLAND MON	TGOMERY		SI	LVER								YES 2 NO
		OAD				101	. ZIP CODI		- 0			IZEN OF WHA	T COUNTRY?
	5321 RANDOLPH R	OAD	IT EVER IN U.S. AR		1			2085				JSA	
	1 Never Married 2 Married	FORCES? 1	YES 2 X		1 1	It yes, sp	ecity Cube	n, Maxica	IIC ORIGIN? (S n, Puerto Rica	ipecify Yes n, etc.)	or No—	14. RACE — Black, W	American Indian, hits, atc.
	3 Wildowed 4 Divorced	IF YES, GIVE V	WAR OR DATES			1 TYES	2 X NO	Specify	<i>f</i> :			Specify:	WHITE
	15. DECEDENT'S EDUC	CATION	16e, DE	CEDENT'S	USUAL O	CCUPATIO	)N		16b. KII	ND OF BUS	INESS/ING		WILLE
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5	(ring	Do NOT u	work done ( se retired.)	during mo	st of working	ng .					
	12	• (		MEMAI	KER								
	17. FATHER'S NAME (First, Middle, Last)		-				18. MOTI	VER'S NA	ME (First, Midd	le, Malden	Surname)		
	FRANCIS	WILLEY					UNI	MON	V				
	19a. INFORMANT'S NAME (Type/Print)		19t	. MAILING	ADDRESS	S (Street a	nd Number	or Rurat F	Route Number,	City or Town	n, State, Zip	Code)	
	MARIE BATES		50	04 FI	LEETW	100D	STRE	EET,	SILVE	R SP	RING	, MD 2	0910
	20s. METNOD OF DISPOSITION 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Remo	wel from State	20b. PLACE	AND DATE	OF DISPOS	ITION (Na	me of		OATE	20c. LO	CATION -	City or Town,	State
	4 Donation 5 Other (Specify)	~	METR	5POL	LTAN	CRE	ATOF	RY	3/22	ALE	XANDI	RIA, V	A
١	21. SIGNATURE DE FUNERAL SERVICE LIC	ENSEE	_		22. E'D	NAME AN	D ADDRE	SS OF FAC	CILITY	FIME	DATI	HOME,	TNC
	Mad J. S	Mans	m SR										., MD 2090
٦	23. PART I. Enter the diseases, or o	omplications the	t ceused the de	ath. Do r	not enter	the mo	de of dyl	ng, auci	h ea cardiac	or respi	ratory an	rest.	Approximata
	ahock, or heart fellure. I	Liet only one cau	se on each line										Interval Between Onset and Death
ŀ	disease or condition	Ross	les -to	en.	10	1/	11.0						200
	resulting in death)	DUNTO	(OR AS A CONSEC	BENCE O	fee	uce	cre						SWA
		a	erale	TAN	A	1801	ساماير	111	,				'/
	Sequentially list conditions, if any, leading to immediate	DUE TO	OR AS A CONSEC	UENCE O	Fy	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	77-1						
	CAUSE (Disease or Injury												
	that initieted events	OUE TO	(OR AS A CONSEC	UENCE O	F):			_					
	resulting in death) LAST	l											
	PART II. Other algolificant conditions	contributing to	deeth but not n	esulting	In the un	deriving	ceuse C	lven in	Part I. 24	. WAS AN	AUTOPSY	24h WF	RE AUTOPSY FINDINGS
						,				PERFOR	MED?	AW	MILABLE PRIOR TO MPLETION OF CAUSE
									— [ ¹ ˈ	YES 2	□ NO	OF	DEATH?
									-			10	YES 2 NO
	25. WAS CASE REFERRED TO MEDICAL			_		28 PI	ACE OF O	EATH (Chi	ock only one)	_			
	EXAMINER?	HOSPITAL:	ER/Outpatient 3	□ DO4	OTHER	R: /			8 Other (Sc				
	27. MANNED OF DEATN	26s. DATE OF	INJURY	26b. TIM		28c. INJ	_	sidence	28d, DESCRI		NJURY OC	CURED	
	1 Natural 5 Pending	(Month, D	ay, Year)	INJ	URY M	WO	RK?	NO	7120.				
	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE O	F INJURY — At hor	me, ferm, s	street, fact				26f. LOCATIO	N (Street a	nd Number	r or Rural Route	Number
	4 Nomicide determined	building,	etc. (Specify)					- 1	City or To	wn, State)			
1	294. CERTIFIER	MAN. To the heat of											
	(Check only one) 2 MEDICAL EXAMINES												
	29b. SIGNATURE AND TITLE OF CENTIFIER			gatto	an, an may o	piritori, ui				piace, en	a dua to tr	ne cause(s) an	d manner as stated.
	296. SIGNATURE AND TITLE OF CERTIFIER	1/h				ı	29c. LICE	NSE NUM	BER 2//		29d. DAT	E SIGNEO (Mo	nth, Day, Year)
	30. NAME AND ADDRESS OF PERSON WING	COMPLETED	DE OF DEATH #===	4 0 m / =	0/4		VC	140	27			9/22	111
	B.N. ROSENBIG		720 F	ARA	2460 2460	OT	AVE	KE	NISIN	670	W, K	18 20	0 895
	31. DATE FILEO (Month, Day, Year)		R'S SIGNATURE										



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DIVISION OF VITAL RECORDS, P.O. BOX

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THE THE SPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or at	ME PRINERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use	OULS	PONTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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93 09672 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH MONTH 3 DAY 20 GYEAR. George Wilson Courtney, Jr. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs, last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 062-14-1883 1 M 2 F 76 Nov. 12 1916 New York 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH MONTGOMERY DIRECTOR MONTGOMERY GENERAL HOSPITAL OLNEY RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Silver Spring 1 TES 2 NO FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 14609 Deerhurst Terrace 20906 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yea, apecify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced IF YES, GIVE WAR OR DATES В White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+) 5 Chemical Engineer Atomic Energy Commission examiner must be notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) George Wilson Courtney, Sr. Nellie Holla BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 2 Nancy T Same as 10 Courtney 20b. PLACE AND DATE OF DISPOSITION (Name of 29c. LOCATION — City or Town, State DATE Suburban 3-22 Silver Spring, Maryland Crematory 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. lan 933 Gist Avenue, Silver Spring, MD 20910 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between ahock, or heart failure. List only one cause on each line, **IMMEDIATE CAUSE (Finel** Onset and Death disease or condition\_ CEREBRAL INFARCT, LEFT CEREBRUM 4 month Injury, or other traumatic event, resulting in death) DUE TO (DR AS A CONSEQUENCE OF) MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? or item 23 shows any Atrial fibrillation 1 YES 2 | NO OF DEATH? 1 XYES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL;
1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 1 TES 2 NO ne 5 🗆 Residence 6 🗆 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investige BY 1 YES 2 NO 2 Accident 28s. PLACE OF INJURY — At home, lerm, street, factory, office building, etc. (Specify) 3 Sulcide 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be determined 4 Homicide 29a. CERTIFIER
(Check only one)

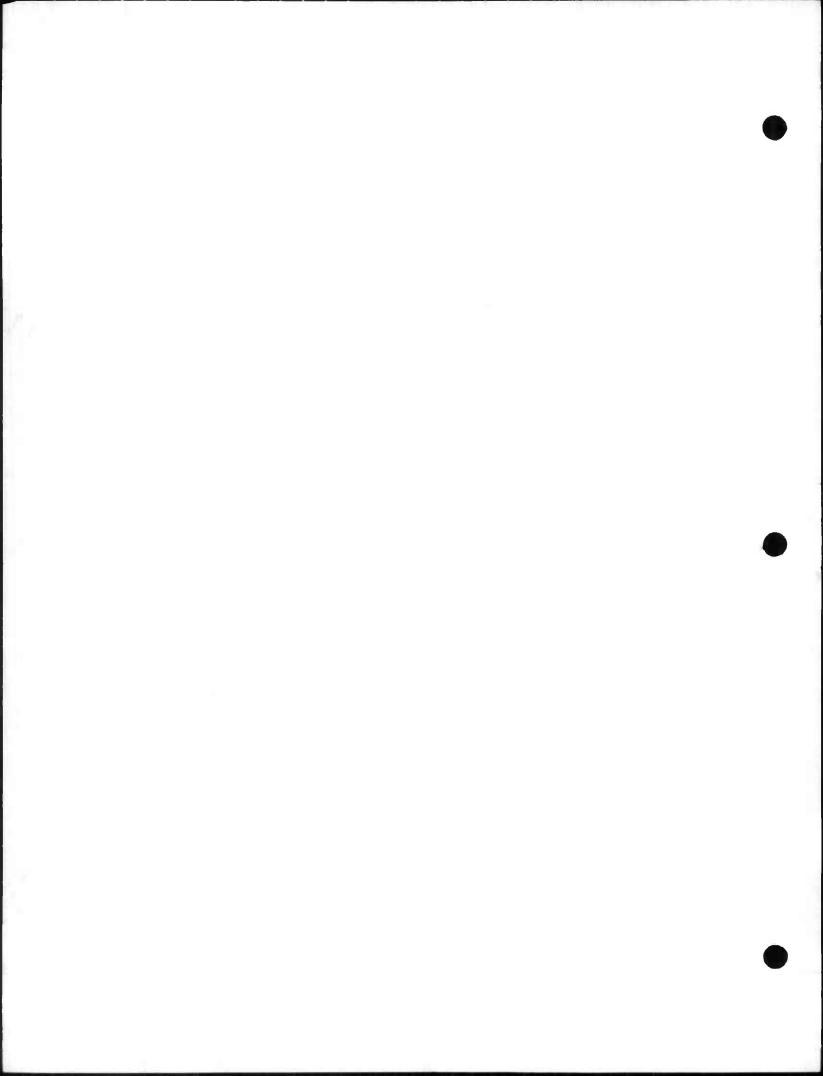
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) quiliant Coagmito, Pathologist 029538 3/22/93

MONTGOHERY

GEN

JULIAN COGGIN Pay REGISTRANIS SIGNATURE & SQ. MAR 25 93

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)



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DIVISION OF VITAL RECORDS, P.O. BOX 13146,	10	IL DI	2 hoc	1 10a
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Į.	IN THE HIGHTAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within gurs after death. Page 6 may be retained by the hospital or	THE TARKETOR: After this certificate has been signed by the attending physician and completelyd in by the funeral director, page 5 should be detached for	is less than 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	the mode of item 92 shows on latery or other transfer event the medical available to notified of once

FOR STATE REGISTRAR	SINIE UF MINNTLA		ICATE OF		MENTAL HYGIEN REG. NO	_	93 09673		
1. DECEDENT'S NAME (First, Middle, Last)	IN CAMI	ודו			2. DATE OF DEATH	2 9	3. TIME OF DEATH		
4. SOCIAL SECURITY NUMBER 114-05-2311			IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 3 - 16 -	1910 F	BIRTHPLACE (State or Foreign Country) OLAND		
HEBREW HOME OF GRI		GTON			EATH	9c. COUNTY OF DEATH MONTGOMERY			
10a. STATE 10b. COUNTY									
	1ERY	ROCK		ZIP CODE		10g CITIZEN	LIMITS?  1 YES 2 NO  OF WHAT COUNTRY?		
						STATES			
11. MARITAL STATUS  1 Never Merried 2 Merried  3 Widowed 4 Divorced	FORCES? 1 YES	2 NO	13. WAS DEC	ENDENT OF HISPAN	NIC ORIGIN? (Specify Yen, Puerto Rican, etc.)	Yee or No-  14. RACE — American Indien, Black, White, etc.  Specify:  WHITE			
15. DECEDENT'S EDUC	:ATION	18e. DECEDENT'S	USUAL OCCUPATION	ON of working	16b. KIND OF BU				
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		HOMEMAK	ER	L 40 1407115710 114					
	YELLIN				,,,	Surname)			
19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a			m, State, Zip Cod	de)		
WILLIAM PARNES					MBIA, MD.	21044			
20 METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 K Remo	20b	other place)							
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23. PART i. Enter the diseases, or c	omplications that caused	the deeth. Do i							
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disease or condition reaulting in death)	-								
	DUE TO (OR AS A	CONSEQUENCE O	F):						
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PART II. Other eignificant conditions	s contributing to death b	ut not resulting	in the underlyin	The second secon	PERFO	RMED?	24b, WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMBINE STOM OF CALIFE		
PART II. Other eignificant conditions	i	ut not resulting	in the underlyin	The second secon		RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
PART II. Other eignificant conditions	s contributing to death b	ut not resulting	in the underlyin	The second secon	PERFO	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
PART II. Other eignificant conditions  RIGHT  25. WAS CASE REFERRED TO MEDICAL	s contributing to death b	ut not resulting	in the underlyin	The second secon	PERFO	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
PART JI. Other eignificant conditions  RIGHT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1   YES 2   NO	HOSPITAL:	out not resulting	in the underlyin  R A C 6  28. Pi  OT/FER: 4/2 Nursing Hom	LACE OF DEATH (Ch	PERFO 1 YES  seck only one)  8 Other (Specify)	RMED?	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO		
PART JI. Other algnificant conditions  RICKT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  Netural 8 Pending	e contributing to death b	ut not resulting	28. P.  OTMER:  A Nursing Hon RE OF 28c. IN. WK	LACE OF DEATH (Ch	PERFO 1 YES	RMED?	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO		
PART JI. Other algnificant conditions  RICKT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1   YES 2   NO  27. MANNER OF DEATH	s contributing to death b  ECCEPO UT  HOSPITAL: 1   Inpatient 2   ER/Outp  28e. DATE OF INJURY	patient 3 DOA  28b. Tilk	28. PI  28. PI  OTMER: 40 Nursing Hon JURY M  1	LACE OF DEATH (Chrone 8   Residence	PERFO 1 YES  seck only one)  8 Other (Specify)	INJURY OCCUR	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2 NO		
PART II. Other algnificant conditions    C	HOSPITAL:  1   Inpatient 2   ER/Outp  28a. DATE OF INJURY (Month, Day, Year)  28e. PLACE OF INJURY building, atc. (Spec	patient 3 DOA  28b. TIM IN.  At home, farm,	28. PI  28. PI  OTMER:  4/ Nursing Hon  RE OF 28c. IN.  WY  M 1   street, factory, office	LACE OF DEATH (Ch.  10 8   Residence 10 10 NO  10 10 NO  10 10 NO  10 10 NO  10 10 NO  10 10 NO  10 10 NO  10 10 NO  10 10 NO  1	PERFO 1 YES  Tother (Specify)  28d. DESCRIBE HOW  28f. LOCATION (Street City or Yown, State to the cause(s) and me	INJURY OCCUR	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2 NO		
PART II. Other algnificant condition:	HOSPITAL:    Impatient   2   ER/Outp   28e. PLACE OF INJURY	patient 3 DOA  28b. Till IN.  — At home, farm, ledge, death occurr n end/or investigation	28. PI  OTHER:  AD Nursing Hon  RE OF 28c. IN.  JURY M 1   street, factory, office  red at the time, date on, in my opinion, of	LACE OF DEATH (Ch.  B   Residence  JURY AT  JURY AT  YES 2   NO  Be end place, and due death occurred at the	PERFO 1 YES  1 YES  Orther (Specify)  28d. DESCRIBE HOW  28f. LOCATION (Street City or Town, State  to the cause(a) and me time, date end place, e	INJURY OCCUR  and Number or any open page stated.  Indiduction the company of the company page stated.	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2 NO  Rural Route Number,		
PART II. Other algnificant conditions  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 8 Pending Investigation 3 Suicide 8 Could not be determined  29e. CERTIFIER (Check only One) 2 MEDICAL EXAMINE  29b. SIGNATURE AND TITLE OF CERTIFIER  2 TALLER MAN  30. NAME AND ADDRESS OF PERSON WHO	HOSPITAL:    Impatient   2   ER/Outp   28e. PLACE OF INJURY	patient 3 DOA  28b. Till IN.  — At home, farm, ledge, death occurr n end/or investigation	28. PI  OTHER:  AD Nursing Hon  RE OF 28c. IN.  JURY M 1   street, factory, office  red at the time, date on, in my opinion, of	LACE OF DEATH (Ch.  B   Residence  JURY AT  JURY AT  YES 2   NO  Be end place, and due death occurred at the	PERFO 1 YES  1 YES  Other (Specify)  28d. DESCRIBE HOW  28f. LOCATION (Street City or Town, State  to the cause(a) and me	INJURY OCCUR  and Number or any open page stated.  Indiduction the company of the company page stated.	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2 NO  Rural Route Number,		
	4. SOCIAL SECURITY NUMBER  114-05-2311  9e. FACILITY NAME (If not institution, give str  HEBREW HOME OF GRI  RESIDENCE OF DECEDENT  10a. STATE  10b. COUNTY  MARYLAND  MONTGON  10e. STREET AND NUMBER  6121 MONTROSE RD.  11. MARITAL STATUS  1 Never Merried 2 Merried  3 Widowed 4 Divorced  15. DECEDENT'S EDUC (Specify only highest grade of the county of	4. SOCIAL SECURITY NUMBER  114-05-2311  9e. FACILITY NAME (II not institution, give street end number)  HEBREW HOME OF GREATER WASHING  RESIDENCE OF DECEDENT  10e. STATE  10e. COUNTY  MARYLAND  MONTGOMERY  10e. STREET AND NUMBER  6121 MONTROSE RD.  11. MARITAL STATUS  1 Never Merried  2 Merried  3 Wildowed 4 Divorced  15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  17. FATHER'S NAME (First, Middle, Last)  19e. INFORMANT'S NAME (First, Middle, Last)  19e. INFORMANT'S NAME (First, Middle, Last)  20e METHOD OF DISPOSITION  1 Description  1 Description  20e METHOD OF DISPOSITION  1 Description  21. SEGMATURE of PUBERAL SERVICE LIST only one cause on a shock, or heart feliure. List only one cause on a shock, or heart feliure. List only one cause on a shock, or heart feliure. List only one cause on a shock, or heart feliure. List only one cause on a shock, or heart feliure. List only one cause on a shock, or heart feliure. List only one cause on a shock, or heart feliure. List only one cause on a shock, or heart feliure. List only one cause on a shock, or heart feliure. List only one cause on a shock, or heart feliure. List only one cause on a shock, or heart feliure. List only one cause on a shock, or heart feliure. List only one cause on a shock, or heart feliure. List only one cause on a shock, or heart feliure. List only one cause on a shock, or heart feliure. List only one cause on a shock, or heart feliure. List only one cause on a shock, or heart feliure. List only one cause on a shock, or heart feliure. List only one cause on a shock of the shock of th	4. SOCIAL SECURITY NUMBER  114-05-2311  9e. FACILITY NAME (if not institution, give street and number)  HEBREW HOME OF GREATER WASHINGTON  RESIDENCE OF DECEDENT  10e. STATE  10e. STATE  10e. STATE  10e. COUNTY  MARYLAND  MONTGOMERY  10e. CT  MARYLAND  MONTGOMERY  10e. STREET AND NUMBER  6121  MONTROSE RD.  11. MARITAL STATUS  1 Never Merried 2 Merried 3 Widowed 4 Divorced  15. DECEDENT'S EDUCATION  (Specify only highest grade completed)  Elementary/Secondary (0-12)  12. WAS DECEDENT EVER IN U.S. ARMED FORCES?  1 YES, GIVE WAR OR DATES  14. DECEDENT'S (Give kind of life. Do NOT utility)  17. FATHER'S NAME (First, Middle, Last)  18. DECEDENT'S  (Give kind of life. Do NOT utility)  19e. INFORMANT'S NAME (Type/Print)  19e. INFORMANT'S NAME (Type/Print)  WILLIAM PARNES  20e METHOD OF DISPOSITION 1 Pauriel 2 Cremetion 3 of Removal from State  CEDAR PAR  21. BECHATURE OF PURPLAL SERVICE DELEGATE  22. PART I. Enter the diseases, or complications that caused the deeth. Do shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Finel disease or conditions, if any, leading to immediate cause. 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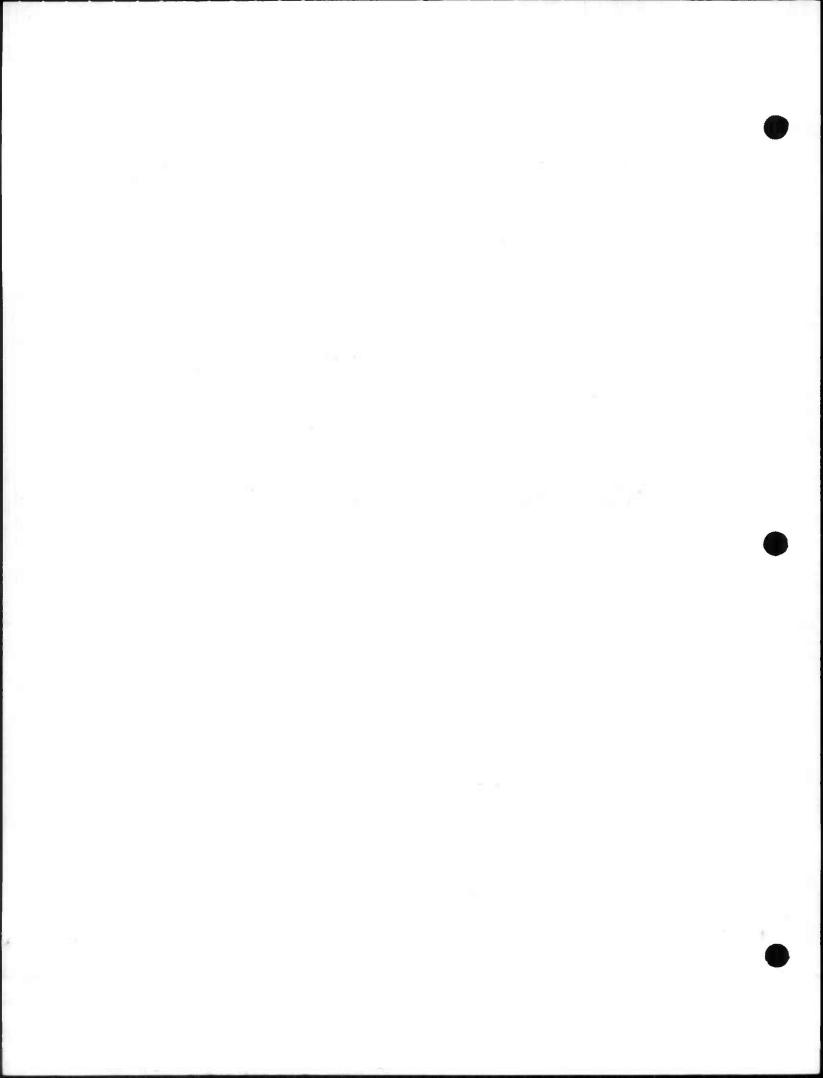
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	DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020	TO THE HIDSTITAL OF MITENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE PROPERTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hyplene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAI CERTIF	RTMEN'	T OF H	IEALTH DEAT	AND	MENT	AL HYGIEN			0 3 0 1 4
1	1. DECEDENT'S NAME (First, Middle, Last)								E OF DEATH	AY		3. TIME OF DEATH
	Robert Dwyer Cawle	У						Ma	rch 23		3	11:30 A.M
		SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.						(Mor	E OF BIRTN		8. BIRTN Countr	IPLACE (State or Foreign
	577-18-0179 1  9a. FACILITY NAME (If not institution, give stree		76 YRS.	- 3		0.5000	ii.ii	-	il 9,19	_		nsylvania
Œ	3724 Manor Road, #:	,		9b. CITY		PR LOCATION		EATN			NTY OF D	
18	RESIDENCE OF DECEDENT				CHEV	ry Ch	ase			M	ontg	omery
DIRECTOR	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN	OR LOCAT	ION						10d. INSIDE CITY LIMITS?
	Maryland Mont	rgomery				y Cha						1 YES 2 NO
PA		4.2			101	. ZIP CODE				10g. CITI	ZEN OF W	VHAT COUNTRY?
106. STREET AND NUMBER  3724 Manor Road, #2  11. MARITAL STATUS  12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO  13. WAS DECEMBENT OF NISPA							On Ecca Bi				States  - American Indian,	
	1 Never Merried 2 X Married	FORCES? 1 X YES	2 NO		It yes, sp	ecity Cube	n, Mexics	in, Puerto	Rican, etc.)	0 100	Black	t, White, atc.
D BY	3 Widowed 4 Divorced		WWII			- 44					оресн	White
COMPLETED	15. DECEOENT'S EDUCAT (Specify only highest grade cor	mpleted)	16a. DECEDENT'S (Give kind of life. Do NOT u	work done	CCUPATIO	ON st of workin	g	16	ib. KIND OF BU	SINESS/INO	USTRY	
P	Elementary/Secondary (0-12)	College (1-4 or 5+) 5+	Private	Pra	ctic	e			Pediat			
O.	17. FATHER'S NAME (First, Middle, Last)		Lily	эста	11	18. MOTH	ER'S NA	ME (First,	Middle, Maiden		an_	
BE C	Thomas Cawley					Aga	tha	Dwy	er			
10	19a. INFORMANT'S NAME (Type/Print)	-							mber, City or Tow			
	Anne Dwyer Hoffmar 20g, METHOD OF DISPOSITION				_		Str	_				MD 20878
	1 \( \times \) Burial 2 \( \times \) Cremation 3 \( \times \) Remove 4 \( \times \) Donation 6 \( \times \) Other (Specify)	from State 20b.	PLACEAND DATE	of DISPOS	SITION (Ne	me of	2	DA	TE 20c. LO	CATION —	City or To	wn, State ng, Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE	ite of it	22.	NAME AN	IN ADDRES	S OF FA	CILITY E	32 211	ver s	ppr 11	ng, Maryland
	· Will EY	our In	M00672	H	ome/	Bethe nsin	esda Ave	-Che	evy Cha Bethe	se, sda,	Mary	rey Funeral yland 20814-
	23. PART I. Enter the diseases, or con shock, or heart failure. Lis	nplications that caused t only one cause on ea	the daath. Do i	not enter	the mo	de of dyl	ng, suc	h as ca	rdiac or respi	lratory arr	est,	Approximate interval Between
	IMMEDIATE CAUSE (Final disease or condition											Onset and Death
	resulting in death) a	Cardiac Ar	CONSEQUENCE O	Б.					Sudden			
_		Coronary A		•	e							Days
CERTIFICATION	Sequentially list conditions, if any, leading to immediate		CONSEQUENCE O									Days
2	CAUSE (Disease or injury											
	that initiated events resulting in death) LAST	OUE TO (OR AS A	CONSEQUENCE O	F):								1
E	d											
ÄL	PART II. Other significant conditions c  1) Diabetes Mell		at not resulting	in tha ur	derlying	cause g	iven in	Part I.	24a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
DE L	2) Infection-Foo							_	1 TYES 2	(X NO		OF DEATH?
W		)t										1 TES 2 NO
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL			_	28. PL	ACE OF OE	ATH (Ch	ack only o	nge)		Ц	
SIC		OSPITAL:	Itlent 3 DOA	OTHER	₹:				er (Specify)			
F	27. MANNER OF DEATH	28a. OATE OF INJURY (Month, Day, Year)	28b. TIM		28c. INJU	JRY AT			SCRIBE HOW II	NJURY OCC	UREO	
ВУ	1 Natural 5 Pending 2 Accident Investigation			M	1 🗌 Y	'ES 2 _	NO					
COMPLETED	3 Suicide 8 Could not be 4 Nomicide determined	28a. PLACE OF INJURY building, etc. (Speci	— At home, tarm,	Hreet, tact	ory, office		,	28t. LO	CATION (Street a or Town, State)	and Number	or Rumi A	oute Number,
PLE	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAL	N: To the best of my knowle	edge, death occum	ed at the t	lme, date	and place,	and dua	to the ca	use(a) and man	nner aa state	ıd.	
Ö	2 MEDICAL EXAMINER: C	On the basis of examination	and/or investigation	n, In my o	pinion, de	eath occure	d at the	time, det	e and place, an	d dua to the	cause(a)	end manner as stated.
BE (	296. SIGNATURE AND TITLE OF CURTIFIER	X - 1/-	1			29c. LICE	NSE NUN	ABER		29d. DATE	SIGNEO	(Month, Day, Year)
10	Anena V	Junas	din			D1	.210	6		▶ Ma	rch	23, 1993
	JOSEPH P Swift M					12.400						
	Joseph P. Swift, M. 31. DATE FILED (Month, Day, Year)	J. 5530 W1S	CONSIN A	venu	ie,	1400	Ch	evy	Chase,	Mary	land	20815
	MAR 26 '93	Julia David		2								



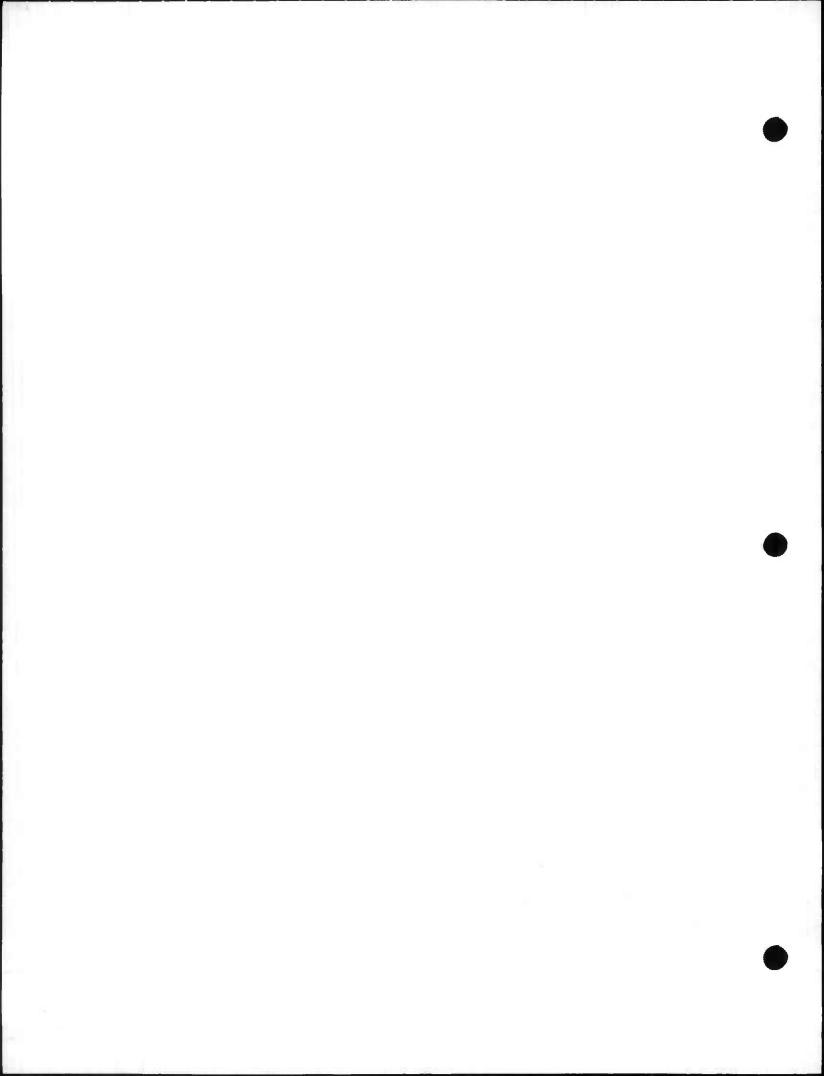
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BALTIMORE, MARYLAND 21215-0020

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BALTIMORE, MARYL	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by it	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be		IMPORTANT: If Item 28 is marked, or Item 23 shows eny injury, or other traumatic event, the medicel examiner must be notified at
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	NG PI	ter th	ath w	mark
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7	10	10	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MP

93 09675 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH DAY 3. TIME OF DEATH ADRIANA J. CHUTTER MARCH 17, 1993 10:30P 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) MAY 20, BIRTHPLACE (State or Foreign Country)
 SUMATRA 1 □ M 2 🏹 📉 HOURS YRS. 218-48-0827 88 1904 Sa. FACILITY NAME (If not institution, give street and number)
BETHESDA REHABILITATION & NURSING 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR CENTER
RESIDENCE OF DECEDENT CHEVY CHASE MONTGOMERY 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY WASHINGTON, D.C. LX YES 2 NO ERAL 10s. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2900 P STREET, N.W. 20007 UNITED STATES

		CATION	44- 0505054510 44014						PE .	
17. FATHER'S NA	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  16b. KIND OF BUSINESS/INDUSTRY  16b. KIND OF BUSINESS/INDUSTRY  16c. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  16c. LEGAL RESEARCH									
17. FATHER'S NA		5+	LAWYER	-				RCH		
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O 194, INFORMANT	'S NAME (Type/Print)		L			oute Number, City or Tox				
HARRIET	T CHUTTER					BETHESDA,			0816	
	Cremation 3 - Rem	oval from State 201	D. PLACE AND DATE OF DI	SPOSITION (Nai	ne of 3/18/9	3 DATE 200. L	DCATION — CI	ty or Town, St	nto	
	1   Burlet 2XXCremation 3   Removal from State 4   Donaties 5   Other (Specify)   MONTGOMERY CREMATORIUM, INC BETHESDA, MAR  22 NAME AND ADDRESS OF FACILITY DOREDTE. A DIMBURE								LAND	
21. SIGNATURE C	ROBERT A. POMPHRE									
- /x	bid 2	lessu.	моовоз			UE, BETH			557 ND 20814	
23. PART I. EI	iter the diseeses, or	complications that cause	d the deeth. Do not e	enter the mod	de of dying, such	as cerdiec or rest	piratory arre	et.	Approximate	
sh	ock, or heart failure.	List only one ceuse on a	ach line.					5	intarval Between Onset and Daath	
IMMEDIATE C	ndition	CARRIORI	TMONADY AD	DECM				i '	Oriset and Daath	
resulting in de	eath)		LMONARY AR	REST						
-				ATLURE				i		
Sequentielly I	Sequentielly list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  CONGESTIVE HEART FAILURE  DUE TO (OR AS A CONSEQUENCE OF):  CORONARY ARTERY DISEASE  DUE TO (OR AS A CONSEQUENCE OF):  d.									
cause. Entar										
CAUSE (Disease that initiated		0.	CONSEQUENCE OF):	DELIDE						
resulting in de	eath) LAST	d.								
	clasificant condition							_		
1 5 1		s contributing to death t	out not resulting in th	ne underlying	ceuse given in F	Part i. 24s. WAS AI PERFO	NAUTOPSY RMED?	AVAILA	AUTOPSY FINDINGS ABLE PRIOR TO	
a OROS	EPSIS					1 YES	2 NO	OF GE	LETION OF CAUSE ATH?	
DEME	NTIA							1 🗆 '	YES 2 NO	
ž										
O EXAMINER?	FERRED TO MEDICAL	HOSPITAL:	ОТ	26. PL	ACE OF DEATH (Chec	ck only one)				
1   YES 2	21	1 - Inpatient 2 - ER/Out	patient 3 DOA 4X	Nursing Home	5 🗆 Residence 6	☐ Other (Specify)				
27. MANNER OF (  1 X Natural  2 Accident	5 Pending	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY	WOI	PRY AT PRK?	28d. DEŞCRIBE HOW	INJURY OCCU	RED		
3 Suicide	8 Could not be	28s. PLACE OF INJURY building, etc. (Spe	f — At home, farm, street cify)	t, factory, office		28f. LOCATION (Street City or Town, State	and Number or	Rural Route N	umber,	
29a. CERTIFIER (Check only one)	MT CERTIFYING PHYSI	ICIAN: To the best of my know	sledge death accurred at	the time det-	and place and door	a the sounded and				
(Check only one)		R: On the beels of sxamination							nanner sa eteled	
	TITLE OF CERTIFIE		- 1			III and the last tendent for				
8	mul	P. Dur	all	_	29c. LICENSE NUM	SER		SIGNED (Month		
P 30 NAME AND A	DDRESS OF PERSON WIL	D COMPLETED CAUSE OF DE	ATH CITEM 2D CATH		D01221		MA	RCH 18	, 1993	
I THE 30 NAME AND A					#340					
Out that he had a	D D *****	T 1/ D 0000								
Out that he had a	S P. DUVAL	L, M.D. 330 3. HEGISTBAR'S SIGN Julia Davidson	1 NEW MEXI	CO AVE	NUE, N.W	., WASHIN	GTON,	D.C. 2	0016	



DIVISION OF VITAL RECORDS, P.O. BOX 68760.

	TO THE HOSPITA OR ATTENTIALS PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos	TO THE RUNERAL DESCRIPTION AND THIS CATIFICATE has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to the state of the s	IMPORTANT If tem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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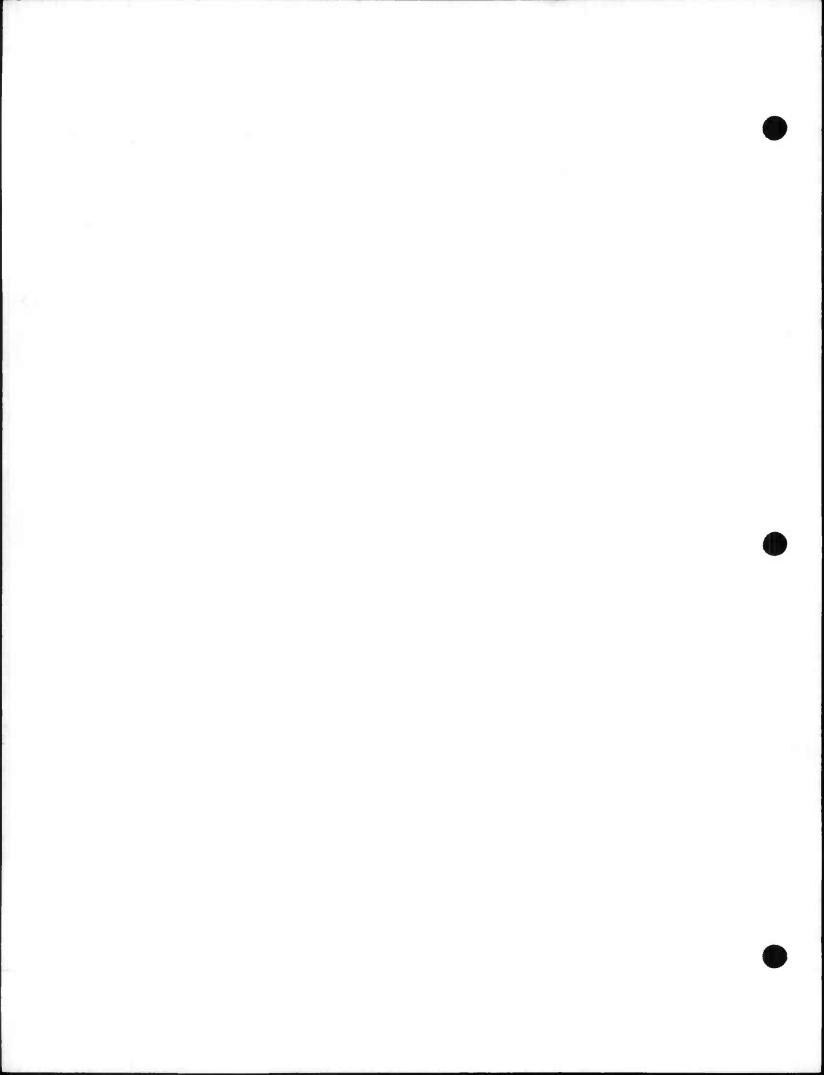
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\*93

32. REGISTRAR'S SIGNATURE
Julia Davidson Rendall

											93	096	76
	FOR STATE REGISTRAR	STATE OF M		DEPAR					MENTAL HYGI				
	1. DECEDENT'S NAME (First, Middle, Last)	· .							2. DATE OF DEAT			3. TIME OF D	EATH
	KENNET	H E.	de	n OUT	ER				MONTH 03	DAY 18	93	6.0	OAM
1 1	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. Is	st birthday)	IF UNDER		IF UNDER	24 HRS.	7. DATE OF BIRTH		8. BIR	THPLACE (State of	or Foreign
	578-34-9937	1 2 M 2 🗆 F	65	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Yes	127	WAS	MINGTON	, DC
	Sa. FACILITY NAME (If not institution, give s	treet and number)			96. CITY	r, TOWN C	R LOCATIO	ON OF DE		9c. C	OUNTY OF		
DIRECTOR	HOLY CROSS HO	SPITAL			SI	LVER	SPR	ING		MO	ONTGO	MERY	
H	10e. STATE 10b. COUNTY	1		10c. CIT	Y, TOWN	OR LOCAT	ION		_			10d. INSIDE (	YTK
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FUNERAL	10e. STREET AND NUMBER					101	. ZIP CODE			10g.	CITIZEN OF	WHAT COUNTR	Y7
1 1 1	14330 CHESTERF	TELD ROA	AD_					2085	3	Ţ	JSA		
15	11. MARITAL STATUS	12. WAS DECEDENT			13.	WAS DEC	ENDENT O	F HISPAN	IIC ORIGIN? (Specif	Yes or No-	- 14. RA	CE — American I	Indian,
ВУ	≥ 3 Wildowed 4 Dhyprogad #F yes, Give was Or Dates 1 Pes 2 1 No Specify: Specify:												
			WWII									WHITE	
TED	15. DECEDENT'S EDUI (Specify only highest grade			ECEDENT'S Give kind of le. Do NOT u	work done	during mo		g	16b. KIND OF	BUSINESS	/INDUSTRY		
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)		GINEE					HANSO	2 TA	den O	משיינו	
N N	17. FATHER'S NAME (First, Middle, Last)	4	EN	GINEE	A		7. 3.0					UIEK	
		den OUTH	210					DRED	ME (First, Middle, Ma				
B	LEENDERT F.  19a. INFORMANT'S NAME (Type/Print)	dell OUT								KEYE			
2		OUTER							Route Number, City or			20052	
	20a. METHOD OF DISPOSITION	OUIER		_				KUA	D, ROCKV				
	1 Buriel 2 ☐ Cremation 3 ☐ Ram	ovat from State	cametery, ci GATE	ematory or c	of DISPOS	SITION (Na	me of	13.57	1		-	Town, State	
1 1	4 ☐ Donation 5 ☐ Other (Specify)	ENSEE	GATE	1 10			METE METE			LVER	SPRI	NG, MD	
	1 David	71. Ta	RD		FR	ANCI	S J.	COL	LINS FUN BLVD.,	W.,	HOME	, INC. SP., MD	2090
П	23. PART I. Enter the diseases, or o	complications that	caused the d	ieath. Do	not enter	r the mo	de of dyi	ng, suci	h aa cardiac or r	eepiratory	arreat,	Approx	cimate
	shock, or heart failure.  IMMEDIATE CAUSE (Final	List only Dne caus	se on each iin	)e.									Between and Death
	disease or condition resulting in death)	Chi	111111	10/1	11/1	21 -	0	11	est				
	resulting in death)	DUE TO	OR AS A CONSI	SOUENCE O	F):	5						_	
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CERTIFICATION	Sequentially list conditiona, if any, leading to immediate	DUE TO	OR AS A CONSE	EOUENCE O	F):								
3	cause. Enter UNDERLYING CAUSE (Disease or injury	C											
트	that initiated events	DUE TO (	OR AS A CONSE	EQUENCE O	F):								
	resulting in death) LAST	d											
1 - 1	PART II. Other significant condition	e contribution to	death but not	regulting	in the u	nderhin	2 001100 0	duen in	Dord I Josephine	S AN AUTOP	- I a	44 14505 415000	W 80100100
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≚	27. MANNER OF DEATH	1 Inpetient 2 I		28b. TIR		rsing Hom 28c. INJ		sidence	6 Other (Specify) 28d. DESCRIBE H		00011050		
	1 Natural 5 Pending	(Month, De			JURY	WO	AK?	1 wo	200. DESCRIBE IN	JW INJURY	OCCUMED		
<u>a</u>	2 Accident Investigation 3 Suicide B Could not be	28e, PLACE OF	INJURY — At h	ome farm	street fac			140	281. LOCATION (St	met and Mu	mhar as Rum	of Bouts Mushas	
	4 Homicide 8 Could not be determined	building, e	Mc. (Specify)			iory, other		-	City or Town, S		NUMBER OF PAULS	ii riodie itamoer,	
LET	29a. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the head of	mu knowle +-	lanth =:	an and	Alma .		ileo wi-s					
COMP	(Check only one) 2 MEDICAL EXAMINE	CIAN: To the best of a										ofe) and =	an advance
8			The state of the s	veatigatti	ori, ur my (	оригион, О				e, and due t	to the cause	e(#) and manner	na stated.
BE	296. SIGNATURE AND ATTLE OF CENTIME	. /					29c. LICE	NSE NUN	MBER	29d.	DATE SIGN	ED (Month, Day, Y	ear)
2	30. NAME AND ADDRESS OF PERSON WH	COMPLETED COM	1	FAA OF C	0.1		1)/	11.	51		3-1	153	
	VV. WARE AREADUREDO UT FERSUN WH	U CUMPLETEU CAUS	E CRUDEATH (IT)	rmi 271 (7/m)	- Print								

2415 MUSGROVE ROAD, SILVER SPRING, MD 20904



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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 11 -CERTIFICATE OF DEATH REG. NO. 1, DECEDENT'S NAME (First, Middle, Last) MARY DEVITA 2. DATE OF DEATH 3. TIME OF DEATN Devita 11:53 P H 22 93 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign Country) 88 1 M 2 XF O-5-156-12-9571 UKRAINE 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF OEATH DIRECTOR HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY PRINCE GEORGES GREENBELT 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8635 GREENBELT RD. 20770 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No- RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried If yes, specify Cuben, Mexican, Puerto Rican, atc.) ВҰ IF YES, GIVE WAR OR DATES 1 TYES 2 TO NO Specify: Specify: 3 Widowed 4 Divorced WHITE COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe ntery/Secondary (0-12) College (1-4 or 5+) 8 HOMEMAKER TA HOME 17. FATHER'S NAME (First, Middle | ast) 18. MOTNER'S NAME (First, Middle, Maiden Surneme) 76 STANLEY KUTZ ANASTACIA BE MICOLIEVICH notified 190. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 MARY PETTIT TTEM SAME AS be 20a, METHOD OF DISPOSITION
1 A Buriet 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE must GREEN MOUNT CEMETERY 4 Donation 5 Other (Specify) 3/26 BATH, PA. examiner 21. SIGNATURE OF FUNERAL SERVICE LIDER M00091 W. W. CHAMBERS CO., RIVERDALE, MD. 20737 or removal medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory street, Approximats shock, or heert failure. List only one ceuse on each line interval Between IMMEDIATE CAUSE (Fine) Onset and Death or other traumatic event, the disesse or condition INTERNAL (MOSTID 1 day MASSIVE RIGHT drd resulting in death) DUE TO (OR AS A CONSEQUENCE OF): MIDDLY CEREBRAL INFARCT CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to If any, leading to immediate cause. Enter UNDERLYING CERFARA L E'DWMA CAUSE (Disesse or injury OUE TO (OR AS A CONSEQUENCE OF): severol that initiated events FIBRILLATION/ ARTEMOSTLE RUSI) resulting in death) LAST ATRIM YPX Item 23 shows any injury, PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. MEDICAL 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 10 1 TES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF OEATH (Check only one) the State OTHER: 1 YES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) marked, or 27. MANNER OF CEATN 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 26c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCUREO INJURY 1 Natural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 99 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED Item 28 4 Nomicide 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 M 2 \_\_ MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(e) end menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER CARLOS 29c. LICENSE NUMBER 29d. DATE, SIGNED (Month, Day, Year) VASQUEZ 01969 3 ▶3/23 93 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) VASQUEZ CARLOS CORPORATE LANDUV 8300 DRIVS 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

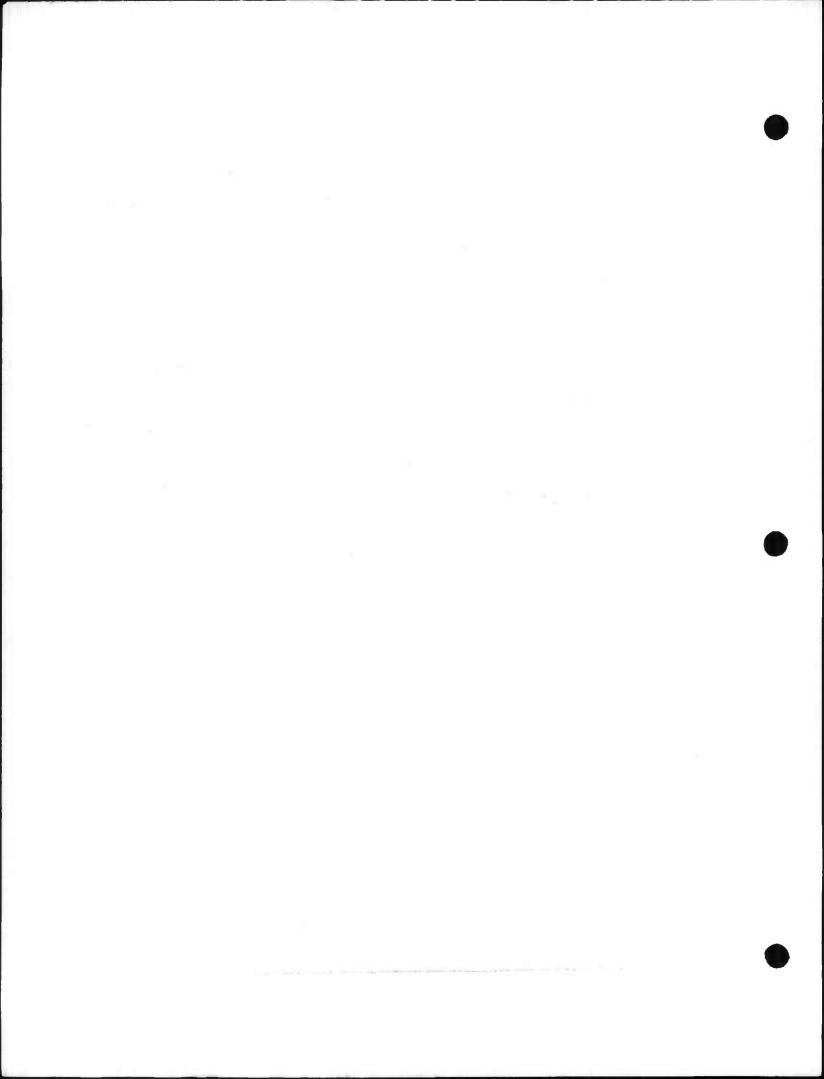
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BALTIMORE, MARYLAND	THE HISPORT OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	TO WE INTERIOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	阜	1	ANT
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_	ø	E.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical ex

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

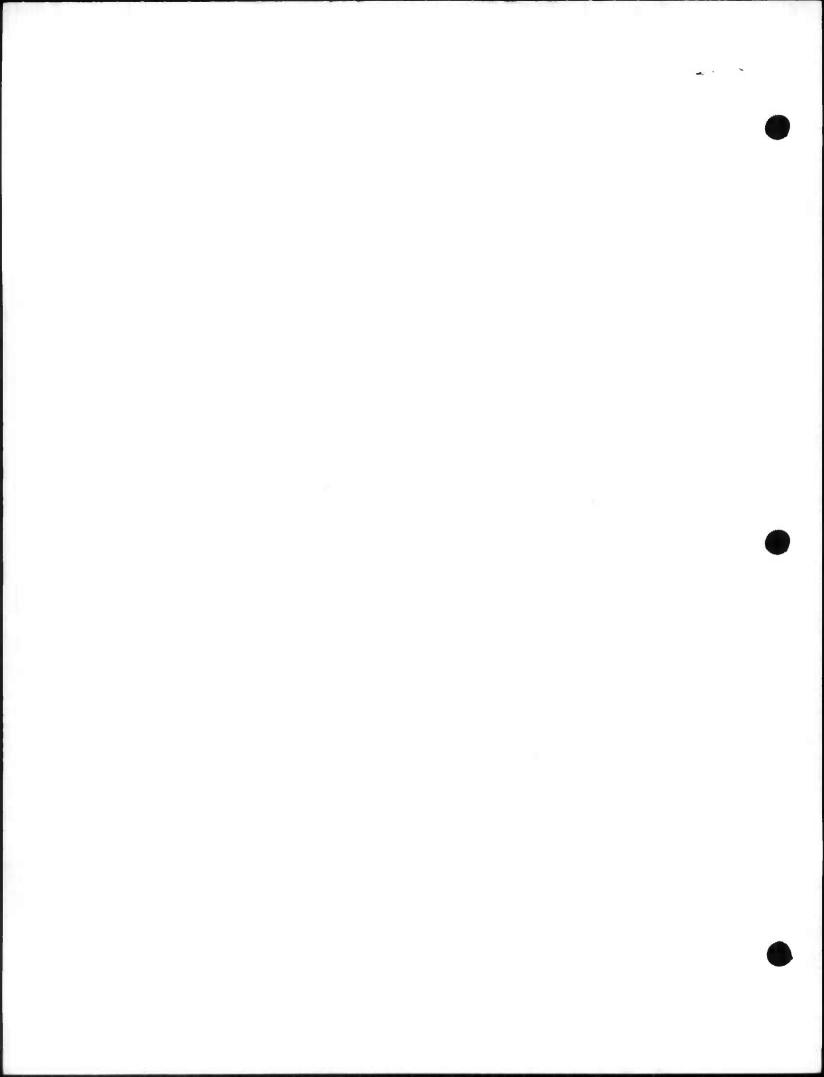
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78		□ <sub>r</sub> M 2 □ F		YRS.	MONTHS	DAYS	HOURS	MIN.	7. DATE OF I (Month, De	ly; Year)	202	Count	
	9a. FACILITY NAME (If not institution, give street	23.	69		9h CITY	TOMON (	R LOCATIO	ON OF DE	Oct.	2/,1		Mar NTY OF D	yland
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DIRECTOR	RESIDENCE OF DECEDENT	nue				KOC1	. ATT1	.e			MC	ntge	mery
R	10a. STATE 10b. COUNTY			10c. CITY	, TOWN O								10d. INSIDE CITY LIMITS?
		Montgomer	У				cvill						1 X YES 2 NO
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BY	3 Widowed 4 Divorced	IF YES, GIVE WAR O	R DATES		'	_ YES	2 XNO	Specify	r:		J	Speci	ην: Nhite
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8	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	IER'S NA	ME (First, Middl	le, Maiden	Sumame)		
BE	Burgess	Dodson							/ Hilde				
2	19a. INFORMANT'S NAME (Type/Print)	_							Route Number, C				
	Upton L. Dodson, o	Jr.				_		, Mt	. Air				21771
	1X Burlet 2 Cremetion 3 Removal 4 Donatton 5 Other (Specify)	I from State	20b. PLACE A cametary, cren MONOC	nd DATE O	her place)	ION (Na	me of	27/0			CATION -		wn, State Maryland
	21. SHANATURE OF FUNERAL BERVICE LICENS		HOHOC	асу					- 1				rey Funeral
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$\dashv$	22 DADT I Enter the diseases	Dulla	M003										50-2805
- 1	23. PART I. Enter tha diseases, or com shock, or heart failure. List	t only ona cause D	n aach line.	וו טע חווי	ot entar i	ne mo	da Dr dyi	ng, sucr	n as cardiac	Dr respi	ratory sm	rest,	Approximata interval Between
	IMMEDIATE CAUSE (Final disease or condition	LUN	G	cn		6 6	,						Onset and Death
	resulting in death) s	DUE TO (OR /											8 mo's
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5	Sequentially list conditions, if eny, leading to immediate	DUE TO (OR /	AS A CONSEO	UENCE OF	):								
S	CAUSE (Disease or Injury												
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR A	AS A CONSEO	UENCE OF	):								
Ä	d												
	PART II. Other significent conditions of	ontributing to deat	h but not re	aulting i	n the unc	erlylng	ceuse g	lven in	Part I. 24a	. WAS AN		24b.	WERE AUTOPSY FINDINGS
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MEC									_   ' '	_ ,	A,10		OF DEATH?  1 YES 2 NO
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A I	25. WAS CASE REFERRED TO MEDICAL EXAMINER?					26. PL	ACE DF DI	EATH (Che	ick only one)				
1Si		OSPITAL:  Inpatient 2 ER/	Outpetient 3	□ DOA	OTHER 4   Nursi	ng Hom	5XXn	sidence	8 Other (Sp	ecify)			
PHYSICIAN	27. MANNER OF DEATH	28a. DATE OF INJU (Month, Day, Ye		28b. TIME	OF JRY	8c. INJ	URY AT		28d. DESCRIE	BE HOW II	JURY OCC	CURED	
BY	1 X Netural 5 Pending 2 Accident Investigation				М		ES 2	NO					
	3 Suicide 6 Could not be	28a. PLACE OF INJ	URY - At hon	ne, tarm, s	treet, facto	y, office			261. LOCATIO City or To	N (Street a	nd Number	or Rural F	loute Number,
E	4 Homicide determined	building, etc. (	Specify)										
	4 Homicide detarmined	building, etc. (	Specify)										
MP	29a. CERTIFIER Check only XX CERTIFYING PHYSICIAN	N: To the best of my k	nowledge, dea										
COMPL	20. CENTIFIED	N: To the best of my k	nowledge, dea										) and menner sa stated.
BE COMPLETED	290. CERTIFIER (Check only XX CERTIFYING PHYSICIAN ONE) 2 MEDICAL EXAMINER: O	N: To the best of my k	nowledge, dea					ed at the	time, data and		d due to th	e cause(a	(Month, Day, Year)
H	290. CERTIFIER (Check only XX CERTIFYING PHYSICIAN One) 2 MEDICAL EXAMINER: O	N: To the best of my kinn the basis of examin	nowledge, dea	rventigation	n, In my op		29c. LICE	ed at the	time, data and		d due to th	e cause(a	
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H	29a. CERTIFIER (Check only XX DERTIFYING PHYSICIAN ONE)  2 MEDICAL EXAMINER: 0  MEDICAL EXAMINER: 0  30. NAME AND ADDRESS OF PERSON WHO CO Daniel Rosenblum,	N: To the best of my kin the basis of axamin	nowledge, dea atton and/or in DEATH (ITEM 400 CC	27) (Type,	n, In my op	Infon, d	29c. LICE	NSE NUM	time, data and	place, and	29d. DATE	e cause(a E SIGNED arch	(Month, Day, Year)
H	290. CERTIFIER (Check only XX CERTIFYING PHYSICIAN ONe) 2 MEDICAL EXAMINER: O	N: To the best of my kind the basis of examin	nowledge, dea atton and/or in DEATH (ITEM 400 CC	27) (Type,	n, In my op	Infon, d	29c. LICE	NSE NUM	time, data and	place, and	29d. DATE	e cause(a E SIGNED arch	(Month. Day. Year) 25, 1993



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Evelyn Dolories Diedrich 03 26 1990  4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in ym. lest birthdey) FUNDER 1 YEAR FUNDER 24 MRS. 7. DATE OF BIRTH 6. AGE (in ym. lest birthdey) FUNDER 1 YEAR FUNDER 24 MRS. 6. AGE (in ym. lest birthdey) FUNDER 1 YEAR FUNDER 24 MRS. 6. AGE (in ym. lest birthdey) FUNDER 1 YEAR FUNDER 24 MRS. 6. AGE (in ym. lest birthdey) FUNDER 1 YEAR FUNDER 24 MRS. 6. AGE (in ym. lest birthdey) FUNDER 1 YEAR FUNDER 24 MRS. 6. AGE (in ym. lest birthdey) FUNDER 24 MRS. 7. DATE OF BIRTH 6. AGE (in ym. lest birthdey) FUNDER 24 MRS. 7. DATE OF BIRTH 7. DATE OF BEATH 7. DATE OF BEATH 8. SCIUNT NAME (if not institution, give street and number) Physicians Memorial Hospital LaPlata Charles Indian Head Charles Indian Head 106. CITY, TOWN OR LOCATION Indian Head 106. STREET AND NUMBER 106. COUNTY Indian Head 106. STREET AND NUMBER 107. ZIP CODE 20640 USA 11. MARITAL STATUS 12. MAS DECEDENT EVER IN U.S. ARMED FORCES? 1 WES 27 XIRO If yes, appecify Cuben, Mexican, Pourto Rican, atc.) 14. Yes, appecify Cuben, Mexican, Pourto Rican, atc.) 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 108. DECEDENT'S USUAL OCCUPATION (Specify only highest grade completed) 109. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Co. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co.	BIRTHPLACE (State or Foreign Country).  Washington D  Y OF DEATH harles  10d. INSIDE CITY LIMITS? 1  YES 2 X NO EN OF WHAT COUNTRY?  4. RACE — American Indian, Black, White, atc. Specify: White
Evelyn Dolories Diedrich 03 26 1990  4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lost birthday) F UNDER 1 YEAR F UNDER 24 MRS. 7. DATE OF BIRTH 6-24-1919  96. CTY, TOWN OR LOCATION OF DEATH 96. COUNTY Physicians Memorial Hospital LaPlata Charles Indian Head  106. CTY, TOWN OR LOCATION F DEATH 96. COUNTY Maryland Charles Indian Head  106. STREET AND NUMBER 106. COUNTY 106. COUNTY 106. CTY, TOWN OR LOCATION Indian Head  107. ZIP CODE 20640 USA  1   Maryland Charles   108. CTY, TOWN OR LOCATION   109. CTIZE   109. CTI	3 06:47 A: M  B. BIRTHPLACE (State or Foreign Country) Washington D  Y OF DEATH harles  10d. INSIDE CITY LIMITS? 1 YES 2 XNO  EN OF WHAT COUNTRY?  4. RACE — American Indian, Black, White, atc. Specify: White
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98. FACILITY NAME (If not institution, give street and number) Physicians Memorial Hospital LaPlata Ch  RESIDENCE OF DECEDENT  100. STATE 100. COUNTY Maryland Charles 100. CITY, TOWN OR LOCATION Indian Head  100. CITY TOWN OR LOCATION Indian Head  100. STREET AND NUMBER 100. STREET AND NUMBER 100. STREET AND NUMBER 101. STREET AND NUMBER 102. STREET AND NUMBER 103. STREET AND NUMBER 104. STREET AND NUMBER 105. STREET AND NUMBER 106. STREET AND NUMBER 107. STREET AND NUMBER 108. STREET AND NUMBER 109. CITY TOWN OR LOCATION INDIA CITY MARYLAND 100. STREET AND NUMBER 100	Washington D Y of DEATH harles  10d. INSIDE CITY LIMITS? 1 YES 2 XNO EN OF WHAT COUNTRY?  4. RACE — American Indian, Black, White, atc. Specify: White
Physicians Memorial Hospital    Physicians Memorial Hospital   LaPlata   Charles   LaPlata   Charles   Charles   Indian Head	harles  10d. INSIDE CITY LIMITS? 1 □ YES 2 ☒ NO EN OF WHAT COUNTRY?  4. RACE — American Indian, Black, White, atc. Specify: White
The state   10b. county   10c. city, town or location   10c. city, town, stell   10c. city, town or location   10c. city, town or location   10c. city, town or location   10c. city, town or location   10c. city, town or location   10c. city, town or location   10c. city, city or location   10c. city, city or location   10c. city, city or location   10c. city, ci	10d. INSIDE CITY LIMITS?  1  YES 2  NO  EN OF WHAT COUNTRY?  4. RACE — American Indian, Black, White, atc.  Specify: White
10e. STREET AND NUMBER  19 Greenwood Place  19 Greenwood Place  11. MARITAL STATUS  11. Maver Married 2 Merried  3 Wildowed 4 Divorced  15. DECEDENT'S EDUCATION (Specify only highest grade completed)  16. KIND OF BUSINESS/INDUS  17. FATHER'S NAME (First, Middle, Last)  18. MOTHER'S NAME (First, Middle, Last)  19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Co.	LMITS?  1 YES 2 XNO  EN OF WHAT COUNTRY?  4. RACE — American Indian, Black, White, atc.  Specify: White
10e, STREET AND NUMBER   10f, ZIP CODE   10g, CITIZE	A. RACE — American Indian, Black, White, atc. Specify: White
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O I William Tour Holling, City Or Town, State, 2p Co	
Carleton J. Diedrich , Jr Rt. 2, Box 176C, Indian head, Md.	
20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION /Name of OATE 20c. LOCATION — Ch	ty or Town State
1 to Burlet 2 Cremation 3 Removal from Stale Commelers, commandory or other (Specify) Francisco or other (Specify) Francisco or other (Specify) Wemorial Gardens 3/29/93 Wall	ldorf,Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  AREHART—ECHOLS FUNERAL I	HOME, INC.
David C. Edde P.O. BOX 567, LA PLAT	TA,MD.
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdlec or reapiratory arresshock, or heart feliure. List only one cause on each line.	Approximate Interval Between
IMMEDIATE CAUSE (Final disease or condition	Onset and Death
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2   Accident   Investigation   26a. PLACE OF INJURY — At home, farm, street, factory, office   26f. LOCATION (Street and Number or City or fown, State)    29e. CERTIFIER (Chack only one)   2   MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) end manner as stated.	RED  Rural Route Number,
2   Accident 3   Sulcide 4   Homicide  26a. PLACE OF INJURY — At home, farm, street, factory, office 4   Homicide  26a. PLACE OF INJURY — At home, farm, street, factory, office 26b. PLACE OF INJURY — At home, farm, street, factory, office 26c. CERTIFIER (Check only one) 2   MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated, one) 29b. SIGNATURE AND TITLE OF CERTIFIER  29c. LICENSE NUMBER 29d. DATE S  29d. DATE S  29d. DATE S	RED  Rural Route Number,cause(a) and manner as stated.
2   Accident   Investigation   26a. PLACE OF INJURY — At home, farm, street, factory, office   26f. LOCATION (Street and Number or City or fown, State)    29e. CERTIFIER (Chack only one)   2   MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) end manner as stated.	RED  Rural Route Number,cause(a) and manner as stated.



TO BE COMPLETED BY FUNERAL DIRECTOR

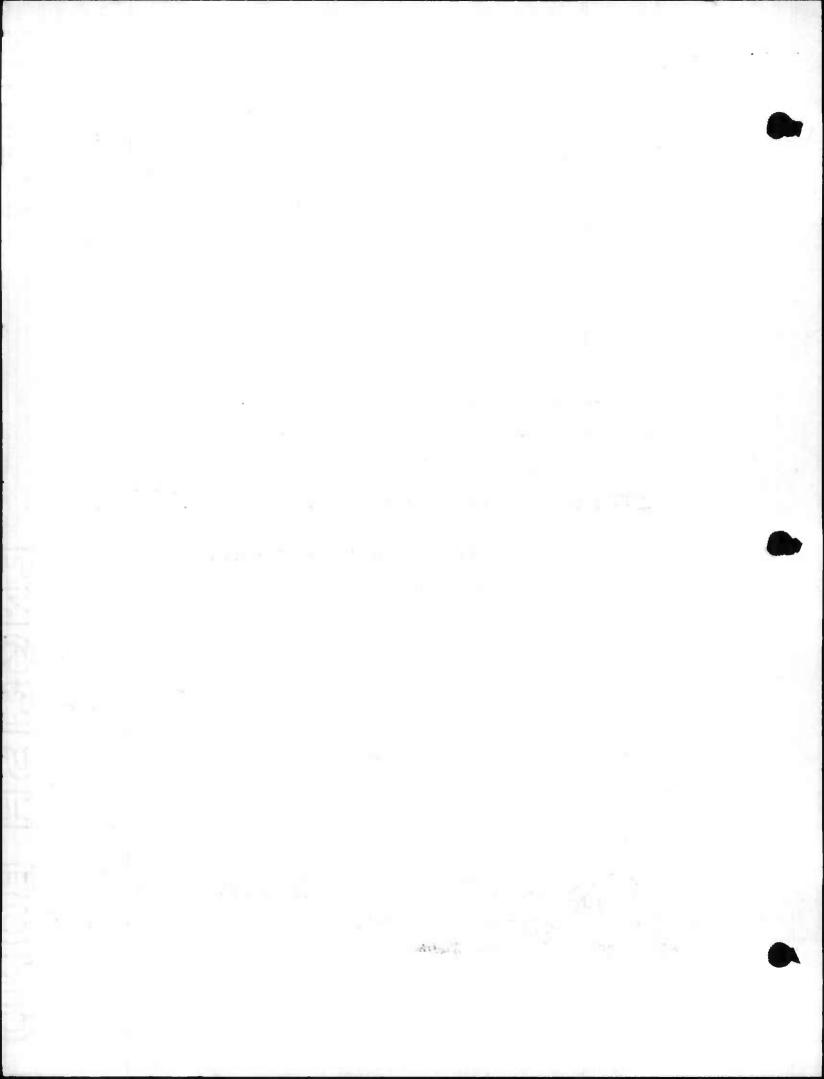
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	TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the	be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene phor to bunal, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

MAR 1 1993

32. REGISTRAR'S SIGNATURE

FOR STATE REGISTRAR	STATE OF N	IARYLAND /				EALTH AND DEATH		YGIENE EG. NO.	-	, 0	0 2 0 0 0
1. OECEDENT'S NAME (First, Middle, Last)  MARY ELIZA	ВЕТН	DAWSON					2. DATE OF D MONTH	EATH DAY	19	YEAR	TIME OF GEATH 2:05PM M
4. SOCIAL SECURITY NUMBER 216-14-9381	5. SEX	6. AGE (In yrs. les 87	t birthday) YRS.		DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BI (Month, Day, 9-24	IRTH : Year) -190	5	8. BIRTHPL Country) Mary	ACE (State or Foreign
90. FACILITY NAME (If not institution, give so Corsica Hills RESIDENCE OF DECEDENT		Cente	r			eville	DEATH		_	een .	
10a. STATE 10b. COUNTY Maryland Tal		1671	7 4 4 7	y, TOWN OR		ION					DI. INSIDE CITY LIMITS?  XXES 2 \( \text{NO}\) NO
Willis Stree	t				101	21625				EN OF WHA	AT COUNTRY?
11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS OECEDEN FORCES? 1 IF YES, GIVE W	YES 2 X	MED 40	11	yes, spe	ENDENT OF HISPA polity Cuben, Mexic 2X NO Spec	an, Puerto Rican,	ecity Yes o	r No-	Black, W Specify:	American Indian, Vhite, atc.
15. DECEDENT'S EDU- (Specify only highest grade Elementary/Secondary (0-12)	CATION completed)  College (1-4 or 5 d	(G life.	ive kind of v Do NOT us	usual occ work done du ne retired.)	iring mo	DN st of working	16b. KINE	O OF BUSIN	ESS/IND	USTRY	
17. FATHER'S NAME (First, Middle, Lest)	:+b- 0		Omen	ancı			AME (First, Middle				
Charles L. Wh.  19a. INFORMANT'S NAME (Type/Print)  Earle Dawson.	-	.19				Maude nd Number or Rura cdova.		ity or Town,		Code)	
20e METHOD OF DISPOSITION 1		20b. PLACE	AND DATE	E OF DISPO	SITION ice)		DATE	20c. LOCA		On .	
21. SIGNATURE OF FUNERAL SERVICE LIC				22. N	ewi	DADDRESS OF F	neral	Home	,P.	Α.	
23. PART I. Enter the diseases, or ahock, or heart failure.  IMMEDIATE CAUSE (Finel disease or condition reaulting in death)	complications tha List only one cau a.	t caused the de se on each line	eth. Do r	le v	the mo		ch ea cardiac	or reapire			Approximate interval Between Onset and Death
Sequentielly list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury	b. DUE TO	OR AS A CONSE	QUENCE OF	F):							
that initiated events resulting in death) LAST	DUE TO	(OR AS A CONSE	QUENCE O	F):							
PART II, Other significent condition	e contributing to	deeth but not	reaulting	In the und	ierlyin	g cause given i		WAS AN AN PERFORM YES 2	IED?	CO	VERE AUTOPSY FINDINGS WAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?  YES 2/1/NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER		ACE OF DEATH (C	Check only one)				
1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5 Pending Investigation	1 Inpettant 2 28e. DATE OF (Month, E	INJURY	28b. TIM	4 Selfural	28c. INJ WC	URY AT HRK?	6 Other (Special 26d, OESCRIE	**	JURY OCC	CUREO	
2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE C building,	F INJURY At he atc. (Specify)	ome, farm,	street, facto	ory, offic	•	261. LOCATION City or You	N (Street an wn, State)	d Number	or Rural Rou	ite Number,
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYS											ind manner as stated.
29b. SIGNATURE AND THLE OF CERTIFIE	and	0				29c. LICENSE N	UMBER 2036		29d. DATI	S/13/	fonth, Day, Year)
30. NAME AND ADDRESS OF REMOON WI	O COMPLETED CAU	SE OF DEATH (ITE	M 27) (Type	Print)		Δ.,	Dur	·ha	. A	1.0.0	11 7



use as the burial-transit permit. Pages 1, 2, 3 should

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NI ENDING PRISICIAN. THE AM EQUIES HALL HE DESTITIONE DE EXECUTEU MISH 24 HOURS STIEL DESTIN PAGE & MAY DE FEISINGE BY THE NOSPITAL	CTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to	after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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MAR 2 5 1993.

93 09681 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1993 23 Mabe1 MARIE Demby March 8:15A.MM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (fn yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Country) 1 M 2 F DAYS HOURS 213--14--7673 YRS 81 09-03-12 MARYLAND 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Memorial Hospital at Easton Easton Talbot RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND **OUEEN ANNES** CENTREVILLE 1 TYES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 21617

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— P.O. BOX 385 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, atc. 14 Never Married 2 Married If yes, specify Cuban, Mexican, P.

1 YES 2 NO Specify: BY Specify: 3 🕅 Widowed 4 🗌 Divorced BLACK COMPLETED 15. DECEDENT'S EDUCATION pecify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Spe Elementary/Secondary (0-12) College (1-4 or 5+) 7th DOMESTIC DOMESTIC 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) James Hicks, Sr. BE HENCY MORRIS 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 HARRY HICKS DEMBY ROUTE 1, BOX 208, CENTREVILLE, MD. 20s. METHOD OF DISPOSITION
1 State | 2 Cremation | 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, Stata 1 N Burial 2 Cremation 3 L 4 Donation 5 Other (Specify) niery, crematory or other plece)
EARLE'S CHAPEL CEMETERY 8-26-93 CENTREVILLE, MD 21. SIGNATURE OF FUNERAL SERVICE CICENSEE 22. NAME AND ADDRESS OF FACILITY BENNIE SMITH FUNERAL SERV. P.O. BOX 1687, EASTON, MD. 21601 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such ea cardiec or respiratory strest, Approximate shock, or haert failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Finsi **Onset and Death** CEmbrounsevlar dinns E/STROKE disease or condition 4414-5 resulting in death) DUE TO (OR AS A CONSEQUENCE OF) Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24b. WERE AUTOPSY FINDINGS

PHYSICIAN: MEDICAL CERTIFICATION 24a. WAS AN AUTOPSY PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) HOSPITAL:
1 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 1 TES ZENO ne 5 🗆 Rasidence 6 🗆 Other (Specify) 4 - Nurs 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigate 1 YES 2 NO BY 2 Accident 26s. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Suicide 8 Could not be 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 4 Homicide

29a. CERTIFIER (Check only 1 Z CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(s) and manner as stated.

SIGNATURE AND TITLE OF CENTIFIERS	29c. LICENSE NUMBER  D 3/466	29d. DATE SIGNED (Month, Day, Year)

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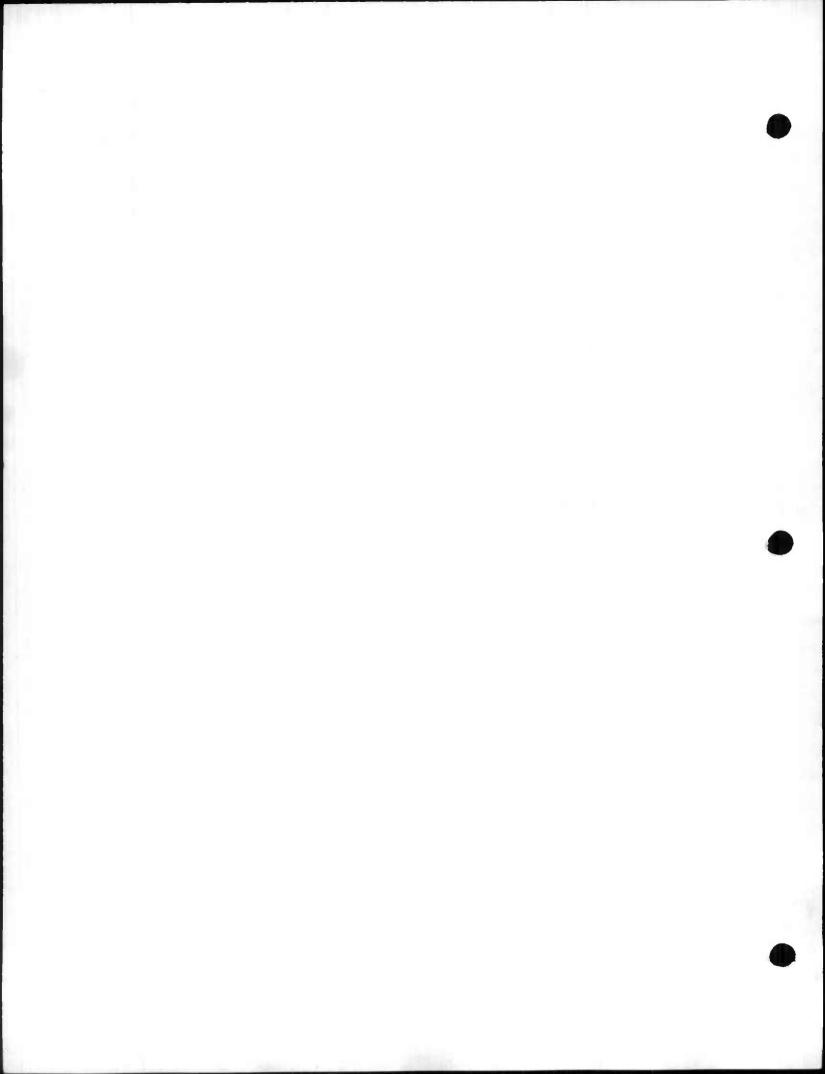
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after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760. FOR STATE REGISTRAR

	1. DECEDENT'S NAME (First	Middle Last	3 T					-	HEG. NO	-		
	Alexo	Inde	ertim	THE	uns	VANS	5		2. DATE OF DEATH ON THE MONTH OF THE MONTH O	うちゃ	3993	RA 4245
	4. SOCIAL SECURITY NUME 220-42-11		5. SEX	6. AGE (In yrs. Ia	444	UNDER 1 YE		MIN.	7. DATE OF BIRTH (Month, Day, Year) 07-20-19	11	6. BIRTHPLA Country) Mary	ACE (State or Foreign
DIRECTOR	RESIDENCE OF DEC	stitution, give s	Adventi			CITAL TOY	OCKV	ION OF DE	ATH	9c. COU	NTY OF DEAT	ТН
5	10e. STATE	10b. COUNT	Y		10c. CITY, T	OWN OR LC	CATION				1.0	d. INSIDE CITY
	Maryland	Mo	ntgomer	У			ersb	urg				LIMITS?  X YES 2 NO
RA	10e. STREET AND NUMBER						101, ZIP COD			10g. CITI	ZEN OF WHA	
UNERAL	8361 Fai	rnave						2087			U.S.	A.
6	1 Never Married 2 🔀 3 Wildowed 4 Divo		12. WAS DECEDEN FORCES? 1 tF YES, GIVE W	VES 2		It yes	Specify Cube YES 2 X NO	n, Mexicen	C ORIGIN? (Specify Yes , Puerto Rican, etc.)	or No—	Black, W	American Indian, Thite, etc.  Black
8	15. DEC	EDENT'S EDU	CATION	16e. Di	CEDENT'S USI	AL OCCUP	ATION		16b. KIND OF BUS	INESS/IND		-140%
PLETE	Elementary/Secondary (0		College (1-4 or 5 +	·) (G	Labo		i most of workii	ng	-2-32-4-536			
once. COMPL	17. FATHER'S NAME (First, M.	ddle, Last)					18. MOT	HED'S NAM	E (First, Middle, Maiden	Cumamal		
111 PF	Samuel M.	Evan	S						nce Matt			
TO BE	19e. INFORMANT'S NAME (7)			19	b. MAILING AD	DRESS (Stre			oute Number, City or Town		Codel	
be not	Florence		ore (Mo	ther	1021	9 Ri	dgel		Dr., Gai			20879 g, MD
must	20e. METHOD OF DISPOSITI 13/2 Burlel 2 Crematto 4 Donation 5 Other	n 3 🗆 Rem (Specify)	-	20b. PLACE cemetery, cre ASN	AND DATE OF D	isposition	(Name of Cemet	tery	1 .		Spri	
xaminer	21. SIGNATURE OF FUNERAL	genvice Lic	ENGEE /	and	au/	SNC	WDEN	SS OF FACE	ERAL HOM			
ca ca	23. PART I. Enter the A	//	omaliantiana that	0.000		ROC	KVILI	E,M	D 20850			
readth and Mental hygene prior to bunal, cremation, or removal.  INS any Injury, or other traumatic event, the medical examiner must be in MEDICAL CERTIFICATION.	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Cardiorespiratory Arrest  1 hr							Approximate interval Between Onset and Death				
natic ev	Sequentially list conditi		15 Ca	OR AS.A CONSE	de	ath						22 hrs
er traur	if any, leading to immed cause. Enter UNDERLYII CAUSE (Disease or injur	NG	BB	rainst	em_bl							77ddays
mal Hygiene prior to bun  y, or other traumatic  CERTIFICATION	that initiated events resulting in death) LAST		HH	yperte	nsion							2 year
- E	PART II. Other significan	nt condition	s contributing to	deeth but not r	esuiting in th	e underly	Ing ceuse g	lven in P	art i. 24s. WAS AN	AUTOPSY	24b. WEI	RE AUTOPSY FINDINGS
			rolism		14	dys	1 4	7.	PERFOR	WED?	AVA COI DF	ILABLE PRIOR TO MPLETION OF CAUSE DEATH?
AN AN	25. WAS CASE REFERRED TO	MEGICAL										
or item 23 YSICIAN	EXAMINER?	MEGICAL	HOSPITAL:			HER:	PLACE OF DE					
red, or item 23 s PHYSICIAN:	27. MANNER OF OEATH		28e. OATE OF	INJURY	28b. TIME OF		ome 5 Re		Other (Specify)  28d. OESCRIBE HOW IN	ILIBY OCC	UDEA	
marked BY PH	2 Accident	ending restigation	(Month, Da	A	INJURY	M 1	WORK? YES 2		OLICINE HOW IN	JURY OCC	OREO	
urs after de mm 28 is ETED		could not ba etermined	building, e	FINJURY At hoote, (Specify)	me, ferm, street	, factory, o	ffice		26t. LOCATION (Street a City or Town, Stelle)	nd Number (	or Aural Route	Number,
2 3 7	29a. CERTIFIER (Check only one) 1 CERTI	FYING PHYSIC	CIAN: To the best of r	my knowledge, de	ath occurred at	the time, d	ate end place,	end due to	the cause(e) end men	ner ee state	d.	manner es stated.
	296. SIGNATURE AND TITLE	OF CERTIFIER	Mach	Kay to	A1.	1		NSE NUMB			SIGNED (Mor	
1 F	30, NAME AND ADDRESS OF	PERSON WHO	end.	1 /			1,40				5//6/	7 7 3
4	31. DATE FILED (Month, Day, Y	HOS KO	32. REGISTRAS	14812		(.01	Lar	4	Rocks./	1,00	ul ho	185)
	MAK 19	'93	Julia.	Davidson	Pandelle.							

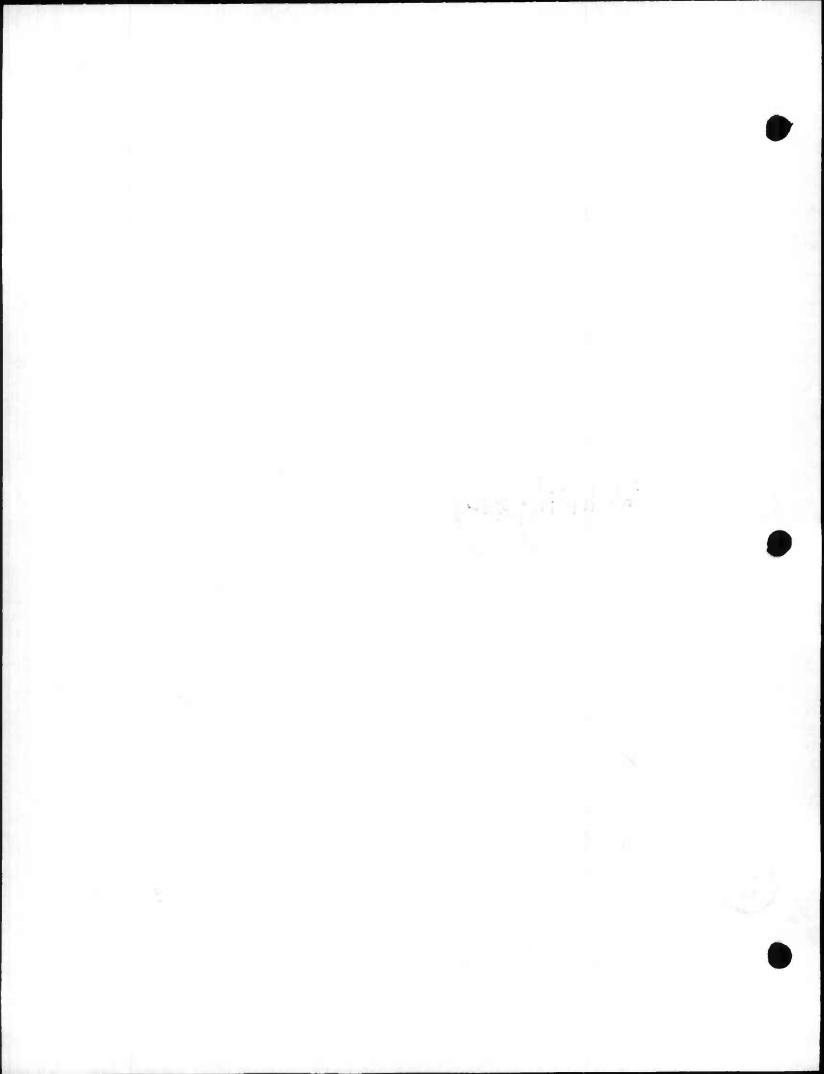
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	
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F VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020 SICIAN: The law requires that the death certificate be executed within 24 flours after death. Page 6 may be retained by the hospital or attending physician. certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should it or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMPLETED BY FUNERAL DIRECTOR
DIVISION OF VITAL RECORDS, P.O. BOX 68760,  TO THE HONDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. The honor that DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the huneral director, page 5 should be detached for use as the burial-trans the reason with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  WINDORFICE: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

	FOR 1 - STATE REGISTRAR	STATE OF MARY	LAND / DEPAR CERTIF	RTMENT	OF H	EALTH	AND MI	ENTAL HYGIEN			, , , , , , , , , , , , , , , , , , , ,
	1. DECEDENT'S NAME (First, Middle, Last)  Anna  I	Eckert						2. DATE OF DEATH	AV V	EAR 3	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER  198-32-2355  90. FACILITY NAME (If not institution, give s	1 🗆 M 2 💢 F	E (In yrs. last birthday) 84 YRS.	MONTHS  9b. CITY	DAYS	IF UNDER HOURS	MIN.	MAR . 15,	a	BIRTHPL Country) YUG	ACE (State or Foreign
DIRECTOR	NATIONAL LUTHI	ERAN HOM	IE		ROC	KVI	LLE				MERY CO.
		11	10c. CIT	BET	HES						Dd. INSIDE CITY LIMITS?  X YES 2 \( \square\) NO
FUNERAL	11033- FAWSI	ETT ROAD			101	ZIP CODE	2085	4		OF WH	AT COUNTRY?
В	11. MARITAL STATUS 1 Never Married 2 Married 3 NXIdowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	S 2 X NO		1 yes, spi	ENDENT OF	F HISPANIC I, Maxican, I Specify:	ORIGIN? (Specify Yes Puerto Rican, etc.)	or No 14.	RACE Black, V Specify:	- American Indian, White, etc.
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	16e. DECEDENT'S (Give kind of ville. Do NOT us HOM	work done r	during mo:	N st of working	7	16b. KIND OF BUS	HOME	TRY	
BE CON	17. FATHER'S NAME (First, Middle, Last) FRANZ PETT(	)				18, MOTH	ER'S NAME ANN	(First, Middle, Maiden A WENOT	Sumeme)		
TO B	190. INFORMANT'S NAME (Type/Print) REV • DR • RICHARD	REICHARD	19b. MAJLING 9701	ADDRESS	(Street e	DR	or Rural Rou	nte Number, City or Town	n, State, Zip Co. E , MD •	208	850
	26e. METHOD OF DISPOSITION  1  Burlel 2  Cremetion 3  Rem  4  Donetion 5  Other (Specify)	oval from State 2	Ob. PLACE AND DATE OF	ther place)			٧ſ	DATE 20c. LOG 3/12 SII	CATION — City		
	21. SIGNATURE OF FUNERAL SERVICE	hoom	)	22. 1	NAME AN	SON(	S OF FACILI	.,INC.	aT 1	IN CI	
ATION	23. PART I. Enter the diseases, prosphock, or heart failure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING	5tro DUE TO (OR AS Arter	the death. Do nach line.  A consequence of a consequence of a consequence of	P:	the mod	de of dylr	ng, such s	s cardiac or reapi	ratory srrest		Approximate interval Between Onset and Death
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEDUENCE DA	<b>ት</b> :							
PHYSICIAN: MEDICAL	PART II. Other algnificant condition	e contributing to death PM ENTA	but not resulting I	n the und	derlying	cause g	ven in Pa	PERFOR	MED?	CO	I ERE AUTOPSY FINDINGS AILABLE PRIOR TO IMPLETION OF CAUSE DEATH?  YES 2 NO
YSICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO	HOSPITAL: 1   Inpatient 2   ER/Ou	tpatient 3 DOA	OTHER	:		ATH (Check	only one)  Other (Specify)			
ВУ РН	27. MANNER OF DEATH  Natural 5 Pending Investigation	28e. DATE OF INJURY (Month, Day, Year)	INJ	M		RY AT RK? ES 2	NO	Bd. DESCRIBE HOW IN			
COMPLETED	3 Suicide 6 Could not be detarmined	building, etc. (Sp						M. LOCATION (Street e. City or Town, State)		ural Route	Number,
COMPL	(Check only 1 ST CERTIFYING PHYSIC one) 2 MEDICAL EXAMINE	CIAN: To the best of my knothing:  R: On the bests of examination	wiedge, death occurre on and/or investigation	nd at the tir	na, date d einlon, de	ath occure	and due to I	the cause(a) end man	ner es stated. I due to the ce	vse(s) en	d manner es stated.
TO BE	THE SUPPLATURE AND TO LEGE CENTY FER	en	mo			29c. LICEN	3 /	38	29d. DATE 910	9	onth, Day, Year)
	Daniel A	sculler mi	1951	Print)	00	cto	rs ?	Ar. 6e	rman	10 wi	n, mp
1	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIG	NATURE 7D								



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) THE MOST WE WINDING PRINCIAN: THE LAW REQUIRES THAT THE DESTINCATE DE EXECUTED WITHIN 24 HOURS ATTER DEATH. PAGE 15 MAY DE RETAINED BY THE hospital of atte	) THE PURISAL DIFFERENT After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use a		APORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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CERTIFICATION

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93 09684 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH MONTH DAY 3. TIME OF DEATH Richard L. Ericsson March 24 1993 4:50 pm 5. SEX 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH B. BIRTHPLACE (State or Foreign January 192 1 1 M 2 | F DAYS HOURS YRS. 353-12-3608 68 Illinois 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Suburban Hospital Bethesda Montgomery RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Maryland Montgomery Chevy Chase 1 YES 2 X NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 4800 Chevy Chase Drive 20815 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 A YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merrie If yes, specify Cuban, Mexican, Puerto Ri IF YES. GIVE WAR OR DATES 1 YES 2 XNO Specify: Specify: 3 Widowed 4 Divorced WW 11 White 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use religed.)
Certified 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 4 Public Accountant Public Accounting 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) Joseph V. Ericsson Jessie K. Abrams 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Hager Ericsson 4800 Chevy Chase Drive Chevy Chase, Maryland 20815 20a METHOD OF DISPOSITION
1 A Burlet 2 Cremetion 3 Removal from State 20b. PLACEANDOATEOF DISPOSITION (Name of cametery, crematory or other place) March 29, 1993

Rock Creek Cemetery 20c. LOCATION — City or Town, State 4 Donation 5 Other (Specify) Washington D.C. Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Avenue Bethesda, Maryland 20814 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Wisconsin M00335 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure, List only one cause on each line. interval Between **IMMEDIATE CAUSE (Final** Onset and Death disease or condition 3 Days resulting in death) Respiratory Arrest DUE TO (OR AS A CONSEQUENCE OF): Antidepressant Drugs Months Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING Staff Aureus Pulmonary Infection l Day CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO Arteriosclerotic Heart Disease COMPLETION OF CAUSE 1 TYES 2 NO OF DEATH?

					1 WES 2 NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER?			28. PLACE DF DEATH	(Check only one)		
1 YES 2X NO	HOSPITAL:  1      M Inpetient 2 ER/Outpetient 3 DOA  4 Nursing Home 5 Residence 8 Other (Specify)					
27. MANNER OF DEATH  1 Netural 5 Pending Investigation	28s. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY	28c. INJURY AT WORK?  M 1 YES 2 NO	28d. DESCRIBE HOW INJURY OCC	CURED	

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and menner as stated.

28e. PLACE OF INJURY — At home, term, street, factory, office building: atc. (Specify)

2 \_\_ MEDICAL EXAMINER: On the beele of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) end menner se stated. 296. SIGNATURE AND TITLE OF AUTHTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

D 10200

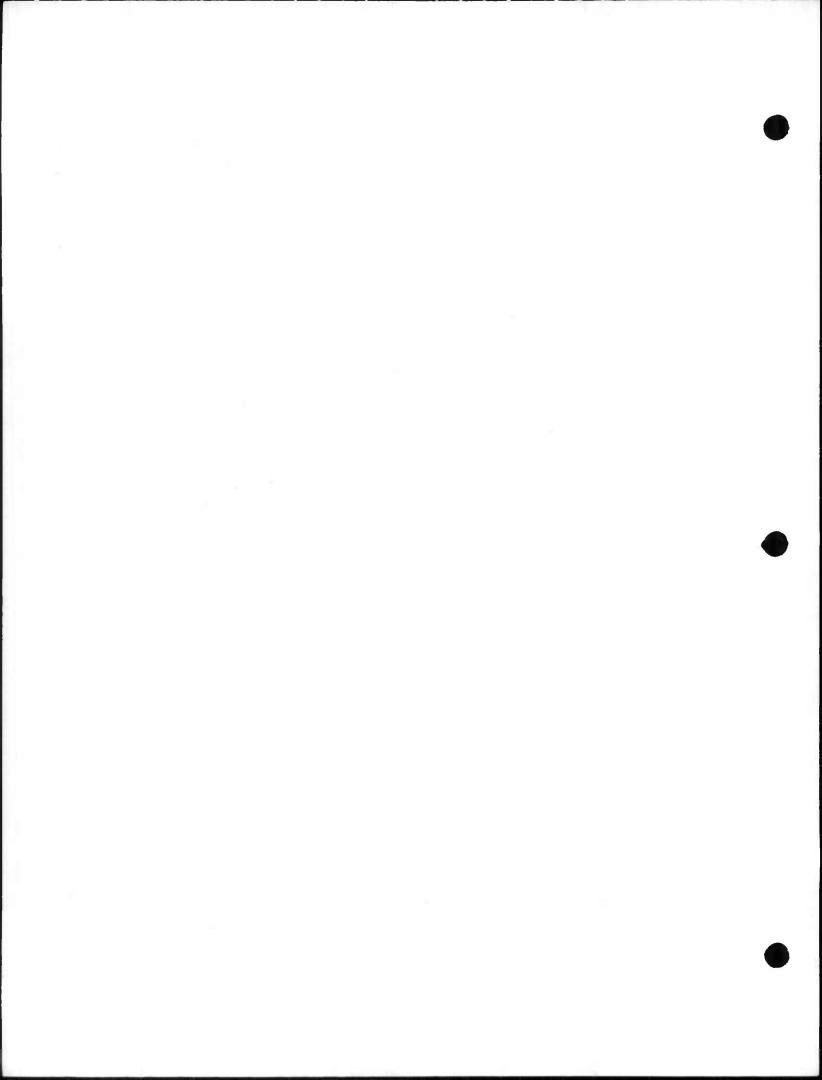
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF

Wisconsin Avenue # 505 Chevy Chase, Maryland 20815 5530 Jack P. Segal

32. RESISTRAN'S SIGNATURE PONCE PO

March 25, 1993

28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)



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		4. SOCIAL SECURITY NUMBER 217-24-2007		5. SEX 6.	AGE (In yo		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATI	E OF BIRTH oth, Day, Year) - 26 -	1930	a. BIRTHPL/ Country)	ACE (State or Foreign
3 should	۳ ا	9a. FACILITY NAME (If not ins		A	- 1	9	-	OR LOCATION OF DI		- 20 -	9c. COUN	TY OF DEAT	
\$° €°	DIRECTOR	RESIDENCE OF DEC	EDENT 10b. COUNTY	TIPSOIT	ay	10c. CITY, 1	OWN OR LOC	ATION	rg		TW		d. INSIDE CITY
		MARYLAND  10c. STREET AND NUMBER	MONT	TGOMERY			ENSING				Lance	1 (	LIMITS?
Sit	FUNERAL	5205 STRATE	MORE A					20895			UNIT	ED STA	T COUNTRY?
-0020 ing physici the burial-	BY FU	11. MARITAL STATUS 1 Never Married 2 3 Divon	Comment of the Commen	12. WAS DECEDENT E FORCES? 1 X IF YES, GIVE WAR	YES 2 OR DATES	□ NO	If yes, s	ECENDENT OF HISPAI specify Cuban, Maxica S 2 X NO Specif	n, Puerto	iN? (Specify Ya Rican, etc.)	a or No	Black, W	American Indian, hits, etc.
MARYLAND 21215-0020 retained by the hospital or attending physic 5 should be detached for use as the burial notified at once.		15. DECE (Specify only Elementary/Secondary (0-	DENT'S EDUC	ATION	-	Give kind of worklife. Do NOT use n	done during n	TION nost of working	16	b. KIND OF BU	SINESS/IND		
AND the hospital detached from once.	COMPLETED	17. FATHER'S NAME (First, Mic		2		OWNER		40 BOTHERIO MA		JANITO		SERV	VICE
RYLA Red by the usid be de	BE	HARRY ERDM	IAN					SOPHIE	PI	ENN			
RE, MARY ay be retained t page 5 should t be notified	2	ANNE ERDMAN	(W	IFE)				MORE AVEN					AND 20895
MORE ge 6 may lirector, pi		20a. METHOD OF DISPOSITION 1 Duriel 2 Cremation 4 Department 5 Other	Specify)			COMFOR			3/			City or Town, LA,VIR	State RGINIA
BALTIMORE, MARYLAND 21215-0020 24 hours after death. Page 6 may be retained by the hospital or attending physician. filled in by the funeral director, page 5 should be detached for use as the burial-tran ion, or removal.		21. SIGNATURE OFFEREN	SERVICE LICE				DANZ	AND ADDRESS OF FA ANSKY—GOL ROCKVILL	DBE				_
E4 hours after filled in by th on, or remove he medical		23. PART i. Enter the dis shock, or ha IMMEDIATE CAUSE (Fins	ert fallure. L	ist only one cause	on each	line.			_			est,	Approximate Interval Between Onset and Death
within npletely cremat		resulting in death)	<b>&gt;</b> .	Adult DUE TO (OR	AS A CO	NSEQUENCE OF):	m I	)istros c	$\mathcal{S}_{\mathfrak{I}}$	ndrom			6 days
Day During	NOL	Sequentially list condition if any, leading to immed		DUE TO (OR	AS A CO	NSEQUENCE OF):							
OS, P.O. BOX he death certificate be so the attending physician a Mental Hygiene prior to niury, or other traum	ERTIFICATION	cause. Enter UNDERLYIN CAUSE (Disease or injur that initiated events	у 🕻 с	DUE TO (OR	AS A CO	NSEQUENCE OF):						-	
de de de	O	resulting in death) LAST	d										
# B > 2 - 1 -	DICAL	PART ii. Other eignifican		contributing to da	eth but n	ot reaulting in	he underlyii	ng ceuse given in	Part i.	24a. WAS AN PERFOI	RMED?	CO	RE AUTOPSY FINDINGS ALABLE PRIOR TO MPLETION OF CAUSE DEATH?
AL RECOR he law requires that has been signed by a Dept. of Health and a 23 shows any	N: ME									(			YES 2 DONO
F VITAL SICIAN: The law certificate has the State Dept 1, or item 23	PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO EXAMINER?  1 YES 2 NO		HOSPITAL:	l/Outpatier		THER:	PLACE OF OEATH (Ch					
_ a => = .	ву Рну	27. MANNER OF OEATH  1 Natural 5 P	ending restigation	28a. DATE OF INJ (Month, Day, )		26b. TIME C	F 28c. IN	IJURY AT PORK? YES 2 NO		SCRIBE HOW	INJURY OCC	UREO	
SIC TENDI TOR: A Si is		3 Suicide 6 C	ould not be etermined	28e. PLACE OF IN building, etc.	JURY — / (Specify)	t home, farm, stre	it, factory, offi	lca		CATION (Street or Town, State,		or Rurel Route	Number,
M. Den.	COMPLET			CIAN: To the beat of my									d manner as stated.
Per Per Per Per Per Per Per Per Per Per	IO BE	29b. SIGNATURE AND TITLE	2 Kon	esty	W.	2.		D 2 6 S	_		29d. DATE	SIGNED (MO	93
25		30. NAME AND ADDRESS OF	School	en beg	F DEATH	(ITEM 27) (Type, Pri	Serre	na Are	#	515	W	hoofs	~ Mtg
		MAR 22 °C	13	32. REGISTRAR'S									
				0									DHMH 16 Day 1/00

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3. TIME OF DEATH

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9:25

B. BIRTHPLACE (State or Formion

Cleveland, OH

10d, INSIDE CITY LIMITS?

14. RACE — American Indian, Black, White, etc.

Specify: White

1 X YES 2 | NO

YEAR

9c. COUNTY OF DEATN

MONT.

10g. CITIZEN OF WHAT COUNTRY?

USA

REG. NO.

MARCH 22,1993

2. DATE OF DEATN

BALTIMORE, MARYLAND 21215-0020

FOR STATE REGISTRAR

4. SOCIAL SECURITY NUMBER

31. DATE FILED (Month, Day, Year)

I. DECEDENT'S NAME (First, Middle, Last)

MATILDA

R.

5. SEX

## DIVISION OF VITAL RECORDS, P.O. BOX 68760.

7. DATE OF BIRTH
(Month, Day, Year)
July 25,1892 270-22-9695 1 ... M 2 X F 100 VDS permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR BETHESDA RETIREMENT CENTER CHEVY CHASE RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWH OR LOCATION MD Montgomery Chevy Chase FUNERAL 10a. STREET AND NUMBER 6412 Western Avenue use as the burial-transit 20815 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No--If yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. MARITAL STATUS If yes, specify Cuban, Maxican, Puerto Ri
1 YES 2 X NO Specify: 1 Never Married 2 Married BY IF YES, GIVE WAR OR DATES 3 X Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION ecity only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INQUISTRY (Spe 10 dary (0-12) College (1-4 or 5+) 8 detached Homemaker Own Home once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ John Gerity director, page 5 should be BE Bridget Moran notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 William R. Patton 6412 Western Ave, Chevy Chase, MD 20815 pe 20a, METHOD OF DISPOSITION
1 Description | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Method | Metho 20b. PLACE AND OATE OF DISPOSITION (Name of OATE must Gate of Heaven Cemetery 3/26 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Joseph Gawler's Sons, Inc. the funeral 5130 Wisconsin Ave, NW, Washington, DC medicai 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, filled in by shock, or heert fellure. List only one cause on each line. **IMMEDIATE CAUSE (Final** he disease or condition completely executed within resulting in death) and com o burial, lous traumatic CERTIFICATION Sequentially list conditions, the attending physician at Mental Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING requires that the death certificate be CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 0 injury. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 34s. WAS AN AUTOPSY and a shows any 1 TYES 2 1 NO t. of h Dept. OR ATTENDING PHYSICIAN: The law 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only on this certificate h item HOSPITAL:
1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 VES 2 K NO GTHER: ne 5 🗆 Residence 6 🗆 Other (Specify) 10 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF INJURY 28c. INJURY AT WORK? marked. 1 X Natural T YES 2 NO BY After 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) L DIRECTOR: A hours after di them 28 is .00 ETED. 3 Sutoide # Could not be 4 [ ] Homicide 29a. CERTIFIER

(Chark ank 1 💢 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. COMPL MPORTANT: II 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER forme 206184 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Thomas Havell, M.D., 4201 Cathedral Ave, NW, Washington, DC 20016

Mandall.

32 REGISTRAR'S SIGNATURE Julia Davidson

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

IF UNDER t YEAR

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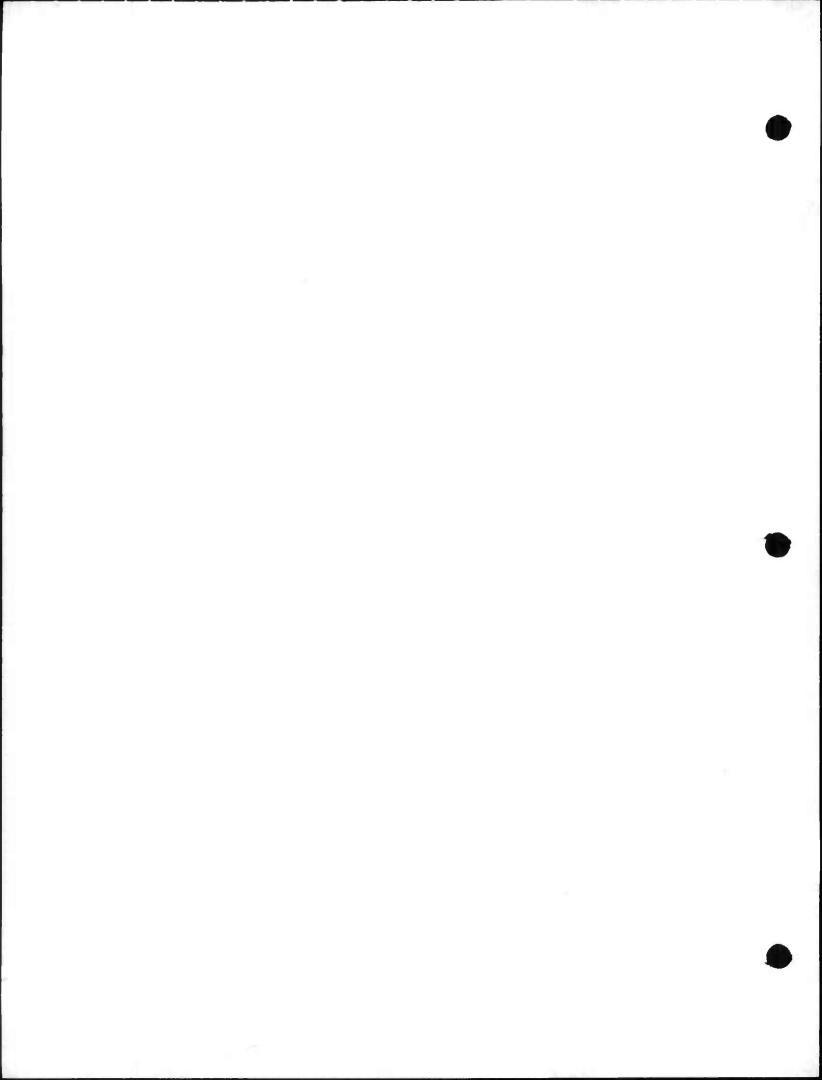
IF UNDER 24 HRS.

HOURS

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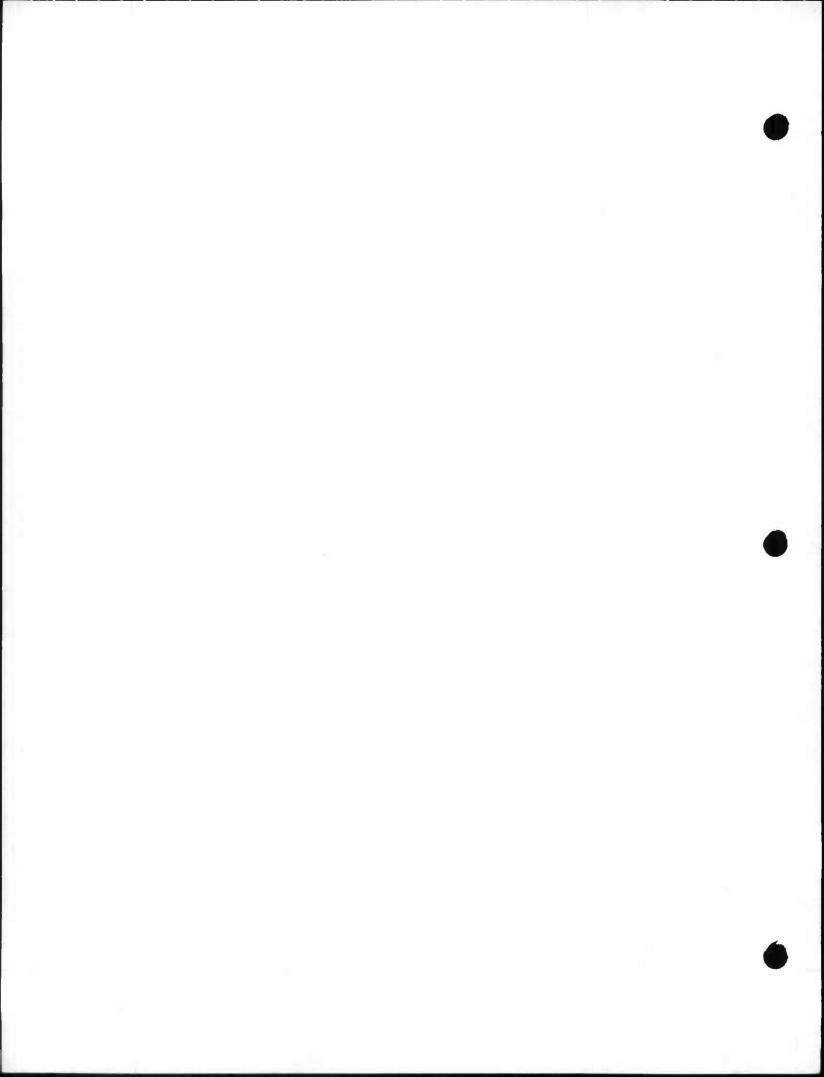
8. AGE (In yrs. last birthday)

20c. LOCATION — City or Town, State Silver Spring, MD Approximete Interval Between Onset and Death Cal WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATHT 1 TYES 2 THO 281, LOCATION (Street and Number or Purel Route Number City or Years, State) 29d. DATE SIGNED (Month Day, 3 3 23 DHMH-16 Rev 1/89



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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache		IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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8	1. DECEDENT'S NAME (FIRST,	GE	E. FE,	4G1	ANS	5					2. DATE OF C	DEATH	3-	YEAR 93	3. TIME OF DEATH 2145 M
7	4. SOCIAL SECURITY NUME 578-05-068(		5. SEX	6. AGE (	'In yrs. lest 7	birthday) YRS.	IF UNDER	DAYS	IF UNDER	1000	7. DATE OF B (Month, Day FEB. 5	/ Monel	16	8. BIRTHP Country) VIRG	
	9a. FACILITY NAME (If not in	stitution, give :	street and number)				9b. CITY	, TOWN	OR LOCATI	ON OF DE	ATH		9c. COU	JNTY OF DEA	ATH
8	WASHINGTON		NTIST HOS	SPITA	AL		TAI	KOMA	PAR	K			MON	TGOME	RY
DIRECTOR	RESIDENCE OF DEC	10b. COUNT				40 - 007	y, TOWN (								
	MARYLAND		TGOMERY				VER								10d. INSIDE CITY LIMITS?
AL D	10s. STREET AND NUMBER	11011	TGOTIERT			211	- V L K		LING	-			40 11 40		YES 2 NO
HA		RAHMS	TERRACE					100		- 20904	·.		10g. C11		IAT COUNTRY?
FUNER	11. MARITAL STATUS	411110	12. WAS DECEDEN	T FVFR II	VIIS ARM	IFD.	12	WAS DEC			C ORIGIN? (Sp	andh. Wan	as Ma	USA	A
	1 Never Married 2		FORCES? 1	X YES	2 NO	0		If yes, sp	ecify Cubi	ın, Mexican	, Puerto Rican	, etc.)	or No-	Black,	— American Indian, White, etc.
B	3 K Widowed 4 Divo	rced		JUTT	AIES			I [] TES	2X NO	Specify:				Specify.	WHITE
입	15. DEC	EDENT'S EDU	CATION		16a. DEC	EDENT'S	USUAL O	CCUPATIO	ON st of world	-	16b. KIN	D OF BUS	INESS/IN		WIII I E
COMPLET	Elementary/Secondary (0		College (1-4 or 5	·)	Ma. I	Do NOT us	e retired.)	coming mo	of or work	'Y					
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8	17. FATHER'S NAME (First, M										NE (First, Middle	, Maiden	Sumame)		
H	ELDRIDGE	E	. FEAGA	NS,					PEA		R.			UCKER	
2	19a. INFORMANT'S NAME (7		Daon								oute Number, C				
	DONNA LEE R	_	DSON							CE, S	SILVER				
	1 Burial 2 Crematic	n 3 🗆 Rem			PLACE AL POTORY, Crem PARKI					0	DATE			City or Town	
	21. SIGNATURE OF EUNERA			- 1 -	ARKL	AWN				SS OF FAC	3/26	ROC.	KVIL	LE, M	D
	1	4/	11	(	1		FRA	ANCI	SJ.	COLL	INS FU	JNER	AL H	OME.	INC.
	Sim	16	Sm	de	77		₽00	UN:	IVER:	SITY	BLVD.	W.	. SI	L. ŠP.	, MD 20901
	23. PART I. Enter the di shock, or h	eert failure	List only one ceu	se on e	the dea ach iine.	ith. Do n	ot enter	the mo	de of dy	ing, such	an cardiac	or respi	ratory ar	rest,	Approximata Interval Between
- 3	IMMEDIATE CAUSE (Fir	iei	0	1	1.	1		T	-1						Onset and Death
	resulting in death)	<b>→</b>	K	2	42	cilo	ry	10	in	we	-			*	
			PUE TO	(OR AS A	CONSTIGI	A J	The	111	1	10	Lum	4	De	alas	e
CERTIFICATION	Sequentially list conditi	ons,	b. VVVV	(OR AS A	CONSEQU	UENCE OF	1		200		0 -	A	100		
CAT	cause. Enter UNDERLY	NG	c.									U			
Ĕ	CAUSE (Disease or inju that initiated events	· .	DUE TO	(OR AS A	CONSEQU	JENCE OF	7:								
E	resulting in death) LAS	' (	d				_								
	PART ii. Other significe	nt condition	ns contributing to	deeth b	ut not re	suiting i	n the un	derivino	cause :	given in F	Part I. 24e.	WAS AN	AUTOPSY	24b. Y	VERE AUTOPSY FINDINGS
EDICAL												PERFOR	MEDY		MAILABLE PRIOR TO COMPLETION OF CAUSE
유											-   10	YES 2	NO		OF DEATH?
2											-			'	YES 2 NO
¥	25. WAS CASE REFERRED TO	O MEDICAL						26. PL	ACE OF D	EATH (Chec	ck only one)				
Sic	EXAMINER?		HOSPITAL:	ER/Outp	ationt 3	DOA	OTHER	3:			Other (Spe	actifu)		_	
PHYSICIAN:	27. MANNER OF DEATH		28s, DATE DF	INJURY		28b. TIM	E OF	28c. INJ	URY AT		28d. DESCRIB		JURY OC	CURED	
ВУР		Pending Investigation	(Month, D	ay, rear)		INJ	M		RK? YES 2 [	NO					
	9 Deviate	Could not be	28e. PLACE D	F INJURY	— At hom	ne, farm, s	treet, fact	ory, offic	•		281. LOCATION City or Tox		nd Numbe	r or Rural Ro	ute Number,
1	4 Homicide	determined		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,						Oily or io	vii, Gielej			
2	29a. CERTIFIER (Check only	IFYING PHYS	ICIAN: To the best of	my know	ledge, deal	th occurre	d at the ti	lme, date	and place	, and due t	to the cause(s)	and man	ner as sta	rted.	
COMPLETED															and manner as stated.
U C	296. SIGNATURE AND TITLE	OF CERTIFIE	R	HK					29c. LICI	ENSE NUM	BER	, 1	29d. DAT	E SIGNED (	Month, Day, Year)
0		W	sum,	ND			63 166	EK Ó III	D	-18	894	,	13	-26	1-93
2	30, NAME AND ADDRESS OF	PERSON WH	O COMPLETED CAU	E OF DE	ATH (ITEM	27) (Type	Print)	011	11	r -	TA 11-	1/1	1 0	101	2 1/2
	NOBHRH	K	KHKIN	)	510	GA	KK	ULL	- TV	2)	THE	)MI	1 4	MKK	MID
	31. DATE FILED (Month, Day:	Mar)	32. REGISTRA	R'S SIGN	ATURE				13%	10.53	30				
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	OR ATTENDING PHYSICIAN:
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JOHN 31. DATE FILEO (Month, Day,

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  UNECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit, to usus after death with the State bept. of Health and Mental Hygiene prior to bunial, cremation, or removal.		Page		
certificate be executed within 24 hours after diding physician and completely filled in by the fygiene prior to burial, cremation, or removal. r other traumatic event, the medical as	il or attending phy	r. page 5 should be detached for use as the burial-		9
certificate be executed within 24 hours after di ding physician and completely filled in by the f tygiene prior to burial, cremation, or removal.	Page	iral din		liner
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OR ATTENDING PHYSICIAN: The law requires that the death IDRECTOR: After this certificate has been signed by the attent ours after death with the State Dept. of Health and Memal I Nem 28 is marked, or Item 23 shows any Injury, or	certifi	ding p	lygiene	10
OR ATTENDING PHYSICIAN: The law requires that the IDIRECTOR: After this certificate has been signed by the lours after death with the State Dept. of Health and Millem 28 is marked, or Item 23 shows any Injury.	death	atten	ental F	الك, 0
OR ATTENDING PHYSICIAN: The law requires the IDIRECTOR: After this certificate has been signed ours after death with the State Dept. of Health it is marked, or litem 23 shows am	at the	by the	and M	y Inju
OR ATTENDING PHYSICIAN: The law required INTERCION: After this certificate has been shours after death with the State Dept. of H is dem 28 is marked, or Item 23 show	res th	igned	ealth s	78 an
OR ATTENDING PHYSICIAN: The law DIRECTOR: After this certificate has to cours after death with the State Dept tem 28 is marked, or item 23	requi	s ueed	Of H	show
OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate hours after death with the State teem 28 is marked, or liter	ne law	has	Dept	п 23
OR ATTENDING PHYSICIA DIRECTOR: After this cert yours after death with the	W. T	ficate	State	Titen
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93 09688 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 2. DATE OF DEATH 93 Mildred Field 3 К. 3 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday. IF UNDER 1 YEAR 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign Country) IF UNDER 24 HRS. 1 🗌 M 2 💢 F 063-10-5103 75 YRS. Nov. 10, 1917 New York 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Suburban Hospital Bethesda Montgomery RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Montgomery Rockville 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1402 Grandin Avenue 20851 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES ZXXNO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2X Married If yes, specify Cuban, Mexican, Puerto Ri IF YES, GIVE WAR OR DATES 1 TES ZXXNO BY Specify. Specify. 3 Widowed 4 Divorced White COMPLETED 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KINO OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home 17. FATHER'S NAME (First, Middle Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Edward Krier Blanche Washburn BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Charles F. Field 1402 Grandin Avenue, Rockville, MD 20a. METHOD OF DISPOSITION

1 Maurial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 3/27/93 DATE 20c. LOCATION - City or Town, State Jefferson Rural Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Catskill, New York 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805 21. SIGNATURE OF FUNERAL SERVICE LICENSEE M00348 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximate shock, or haart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition reaulting in death) PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, A CONSEQUENCE OF If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury eun Hedden that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 1 YES 2 | NO 1 YES 2 1 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 Sinpatient 2 ER/Outpatient 3 DOA OTHER: 1 TES 2 NO 4 - Nursing Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28a. OATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 28d. OEŞCRIBE HOW INJURY OCCURED 5 Pending Investige 1 Netural 1 YES 2 NO BY 2 Accident 26s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Soscity) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 1 🖫 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) end manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 290. SHANTURE AND TITLE OF CHEMPTER

, MA

DEATH (ITEM 27) (Type, Print)

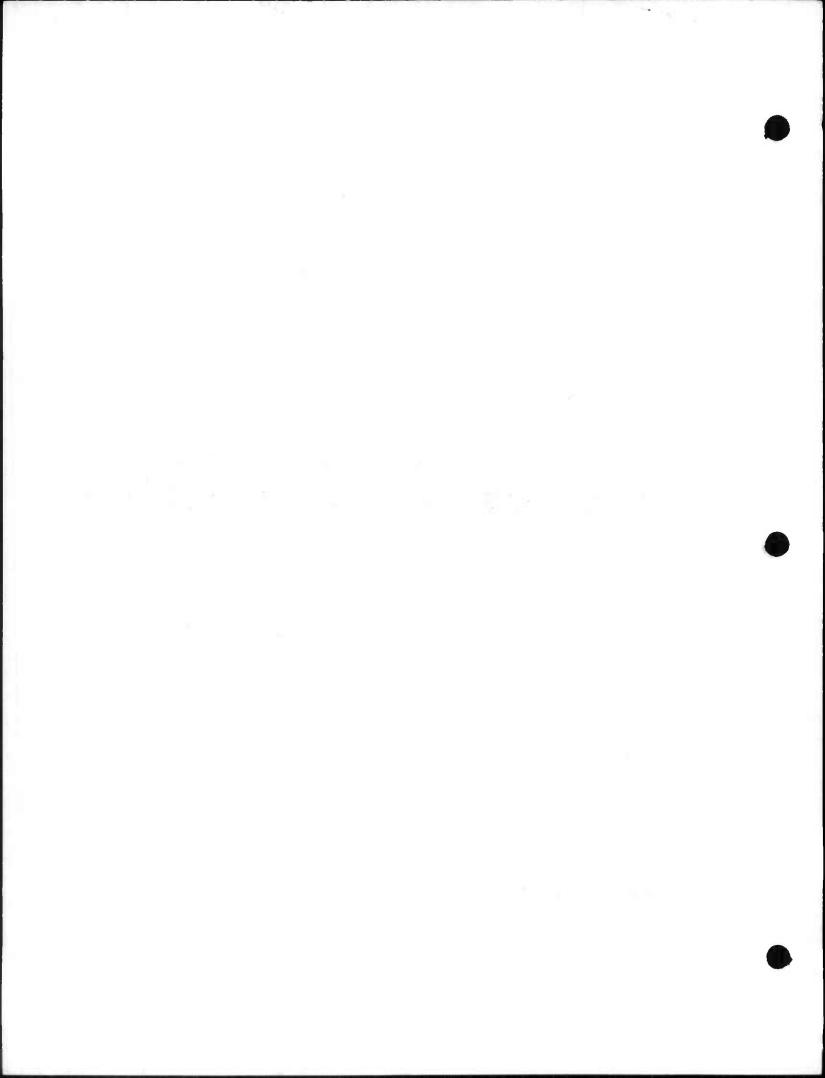
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32. REGISTRAR'S SIGNATURE

29c. LICENSE NUMBER

PRINCE PHILIP DR.

29d. DATE SIGNED (Month, Day, Year)



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BALTIMOR	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 mi	=10 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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	Jin 2	OR: After this certificate has been signed by the attending physician and completely fi
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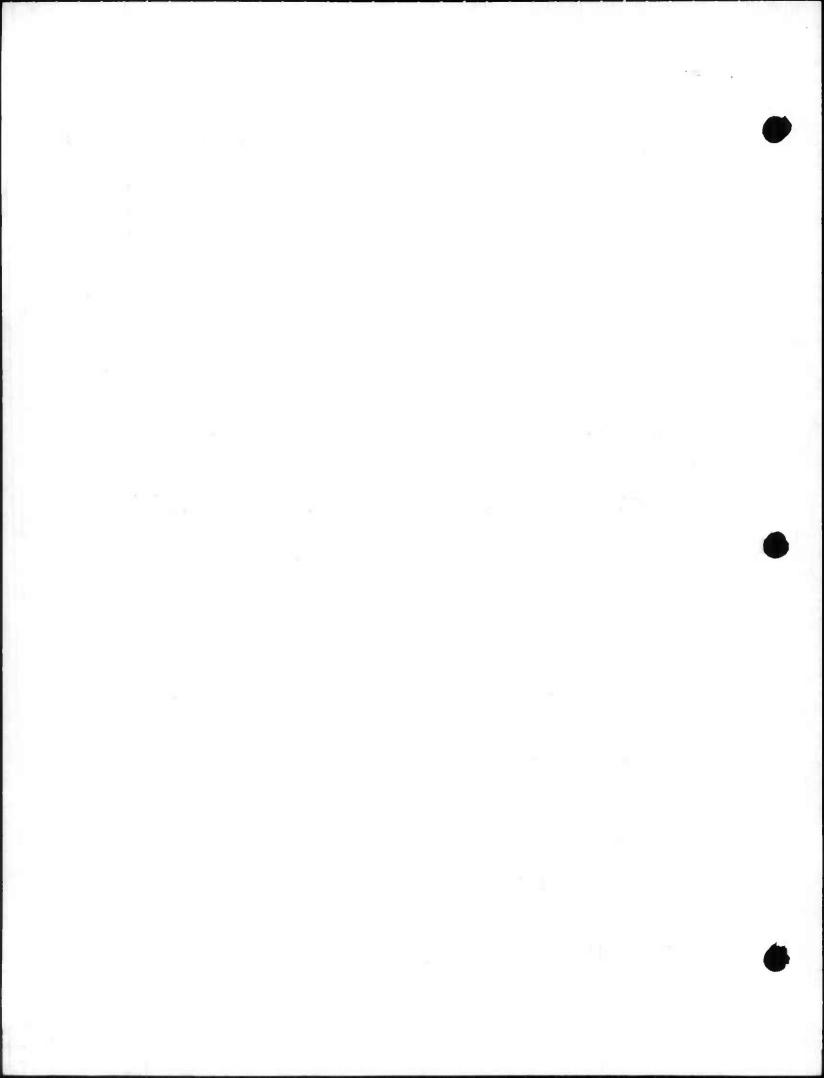
MAR 1 7 1993

- 1	1. DECEDENT'S NAME (First, Middle,	Last)		RTIFICATE		DEATH	2. DAT	REG. NO.			3. TIME OF DEATH
	MARY REGEN		2				3		<b>1993</b>	YEAR	11:02A
	4. SOCIAL SECURITY NUMBER 219-44-1894		AGE (In yrs. les	t birthday) IF UNDER	1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DAT	E OF BIRTH Wh. Day, Year)		8. BIRTH Countr	PLACE (State or Foreign
	9a. FACILITY NAME (If not institution,	give street and number)		9b, CITY	TOWN	OR LOCATION OF		20 20	9c. COUN		
TOR I	Memorial Hosp		on, MD	Inc		Easton				Talb	oot
DIRECTOR	10a. STATE 10b. C	OUNTY		10c. CITY, TOWN C		TION					10d. INSIDE CITY LIMITS?
		lbot		Trapp	е						1 TES ZXNO
¥ I	10e. STREET AND NUMBER	D			10	f. ZIP CODE					HAT COUNTRY?
FUNERAL	31458 Bruces		VED IN II C AD	MED 142	WE DE	21673 CENDENT OF HISP	AANO ODIO	# 10 M 14 W -		ISA	
à l	1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT E FORCES? 1 IF YES, GIVE WAR			f yes, sp	ecity Cuban, Mexi	can, Puerto		or No		- American Indian, i, White, etc. by: White
	15. DECEDENT' (Specify only highest	S EDUCATION grade completed)	(G	CEDENT'S USUAL OF			16	b. KIND OF BUS	HNESS/INDO	JSTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5+)	522.5	Do NOT use retired.)	o ml			Th a mms	t - F		C+ cm c
COMPL	12 17. FATHER'S NAME (First, Middle, Le	at)		ales Cl	err		_	Middle, Meiden		ерт	. Store
- 1	Frederick Re							cClosk	,		
BE	19a. INFORMANT'S NAME (Type/Print		198	. MAILING ADDRESS	(Street		_			Code)	
2	Charles F. I	oster		2626 Me	ado	wbrook	Ro	ad, Fe	edera	lsb	ourg, MD
	20s METHOD OF DISPOSITION 1 Buriet 2 Cremetion 3	Removal from State	20b. PLACE A	AND DATE OF DISPOS	ITION (N	ame of	1		CATION — C		•
	4 ☐ Donation 5 ☐ Other (Specify 21. SIGNATURE OF FUNERAL SERVI		Spri	ng Hill				-17 Ea	ston	, M	D 21601
	21. SIGNATURE OF FUNERAL SERVI	CE LICENSEE				nd address of i		l Home	P.A	١.	
		MERCERO.		57 2	00	S. Har	rise	on St.	. Ea	sto	on, MD
	23. PART I. Enter the disease shock, or heert fall IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. MA 55 / O	on each line							est,	Approximate interval Betwee Onset and Dea
		_									
	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	с	R AS A CONSEC								
AL CERTIFI	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	c	R AS A CONSEC	DUENCE OF):	derlyin	g ceuse given i	n Part I.	24a. WAS AN PERFOR	MED?	24b.	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDICAL CERTIFI	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significent con	c	R AS A CONSEC	DUENCE OF):	derlyin	g ceuse given i	n Part I.	PERFOR	MED?	24b.	AWAILABLE PRIOR TO COMPLETION OF CAUSE
AN. INTERIORE OFFICE	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significent con	d. DUE TO (OF	R AS A CONSEC	OUENCE OF):	28. P	g ceuse given i		PERFOR	MED?	24b.	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	If airy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significent con Appeters  25. WAS CASE REFERRED TO MEDIC EXAMINER?  1   YES 2   NO	ditions contributing to de Melle Truc	R AS A CONSECUTION OF PARTIES OF	DUENCE OF):	28. P	LACE OF DEATH (C	Check only	PERFOR  1 VES 2	MED?		AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDICAL CERTIFI	If airy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significent con  AND ATTENDED CON  25. WAS CASE REFERRED TO MEDIC EXAMINER?  1 YES 2 NO  27. MANNEB-OF OEATH  1 Netural 5 Pending	d.  DUE TO (OF d.  d.  Mellitons contributing to de de de de de de de de de de de de de	ath but not r	DUENCE OF):	28. Pi ing Hon 28c. IN,	LACE OF OEATH ((	Check only	PERFOR	MED?		AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
TED BY PHYSICIAN: MEDICAL CERTIFICATION	If airy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significent con  AND ATTENDED CON  25. WAS CASE REFERRED TO MEDIC EXAMINER?  1 YES 2 NO  27. MANNEB-OF DEATH  11. Netural 5 Pending	DUE TO (OI  d.  ditions contributing to de  Mellitus  Mellitus  MOSPITAL: 15 Inpatient 2   El  28s. DATE OF IN. (Month, Day.  stion ot be	R AS A CONSECUTION OF THE PROPERTY OF THE PROP	equiting in the un	28. Prit: sing Hon 28c. IN, W(	LACE OF GEATH (I	Check only	PERFOR  1 VES 2	MED?	UREO	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
ETED BY PHYSICIAN: MEDICAL CERTIFI	If airly, leading to immediate cause. Enter UNDERLYING CAUSE. (Disease or injury that initiated events resulting in death) LAST  PART II. Other significent con  Application of the control of the contro	DUE TO (OI  d.  ditions contributing to de  Mellitus  Mellitus  MOSPITAL: 15 Inpatient 2   El  28s. DATE OF IN. (Month, Day.  stion ot be	RAS A CONSECUTION OF THE PROPERTY OF THE PROPE	DUENCE OF):  DOA OTHER DOA 4 Nun  DOB INJURY M  The farm, street, fact	28. Prit: sling Hon 28c. IN. WC 1 Dory, office	LACE OF OEATH (to the 5 Great Residence 1) URY AT JRK? YES 2 NO	Check only  6 Ott  28d. Ol  28t. LC  Cit	PERFOR  1 YES 2  Wer (Specify)  ESCRIBE HOW II  CATION (Street a yor Town, State)	NJURY OCC	UREO  Or Rural F	COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
ED BY PHYSICIAN: MEDICAL CERTIFI	If airly, leading to immediate cause. Enter UNDERLYING CAUSE. (Disease or injury that initiated events resulting in death) LAST  PART II. Other significent con  Application of the control of the contro	AL HOSPITAL:  11 Inperient 2 Eight 28s. DATE OF IN. (Month, Day, and the bell of the bell of the bell of the best	RAS A CONSECUTION OF THE PROPERTY OF THE PROPE	DUENCE OF):  DOA OTHER DOA 4 Nun  DOB INJURY M  The farm, street, fact	28. Prit: sling Hon 28c. IN. WC 1 Dory, office	LACE OF OEATH (to the 5 Great Residence 1) URY AT JRK? YES 2 NO	Check only 28d. Oil 28d. Oil 28d. Cil	PERFOR  1 YES 2  Wer (Specify)  ESCRIBE HOW II  CATION (Street a yor Town, State)	NJURY OCC	UREO  OF Bural F	AMARABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO

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32. REGISTRAR'S SIGNATURE



DHMH-18 Rev 1/89

FOR STATE REGISTRAR

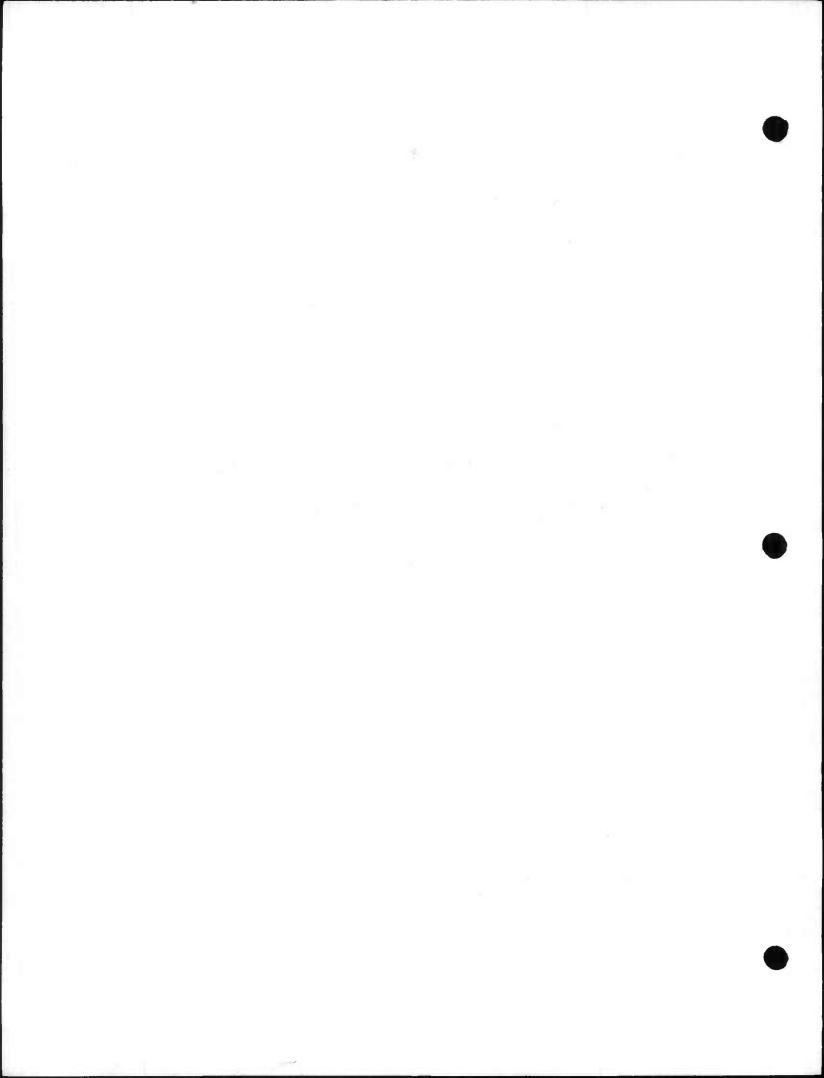
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1	TO THE HOSPINE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within seminurs after death. Pag	TO THE FAMERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral dis
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Day.		D.
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	1. DECEDENT'S NAME (First, Middle, Last) WALKER MORR	IS FULLE	$\mathbf{R}$			3 14	199	3. TIME OF OEATH 12:35 AM
1	4. SOCIAL SECURITY NUMBER 192-07-4314	1XXM 2 □ F 9	(In yrs. last birthday) _	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 7-28-18		BIRTHPLACE (State or Foreign Country) Georgia
20	98. FACILITY NAME (If not institution, give st William Hill RESIDENCE OF DECEDENT		е	96. CITY, TOWN	OR LOCATION OF DI	EATH	9c. COUNTY Tal	
DIRECTOR	100. STATE 10b. COUNTY Maryland Talb		7.7	Mich				16d. INSIDE CITY LIMITS? 1 YES 2 X NO
EHAL	100. STREET AND NUMBER 23882 New Land	Drive		1	21663		10g. CITIZEN	OF WHAT COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Merried 2 Merried 3XXVIIIdowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 (X) YES IF YES, GIVE WAT OR D W W I—Na	2 NO	If yes,	ECENOENT OF HISPAI specify Cuban, Mexics ES 2 NO Specif	NIC ORIGIN? (Specify Yenn, Puerto Rican, etc.) y:	e or No— 14.	RACE — American Indien, Black, White, etc. Specify: White
COMPLETED	15. DECEDENT'S EOUC (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	life. Do NOT use	vork done during i se retired.)		16b. KIND OF BU		
- N	1.2 17. FATHER'S NAME (First, Middle, Last)	4	Execu	tive		ME (First, Middle, Maide	n Sumame)	or Company
2 2	Jones A. Ful  199. INFORMANT'S NAME (Type/Print)  William M. Ful		19b. MAILING	ADDRESS (Street	t and Number or Rural	ie Morris Route Number, City or To ive, Chu	wn, State, Zip Co	St.Michae
	20s. METHOD OF OISPOSITION  1	20	b. PLACE AND OATE	OF OISPOSITIO	N (Name	OATE 20c. L	OCATION — City	y or Town, State  y Marylan
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		News	AND ADDRESS OF FA	ciuty ral Home	DA	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS )	A CONSEQUENCE OF	F):				
ΕI	resulting in death) LAST							1
CER	Williams Co. Passer, Leave	1						
MEDICAL	2477 // 000 - 1 - 1/1 - 1 - 1/1	s contributing to death in the self of the	but not resulting i	in the underly	ing cause given in		N AUTOPSY PRMED? 2 13 NO	24b. WERE AUTOPSY FINDIN AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
MEDICAL	PART II. Other significent condition  Allowoodle  Love by VASIA  25. WAS CASE REFERRED TO MEDICAL EXAMINER?	nosis ular insuffi HOSPITAL:	ciency	26. Оти <b>É</b> R:	PLACE OF DEATH (C)	PERFC 1 VES	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
Y PHYSICIAN: MEDICAL	PART II. Other significent condition  All hards cle  Larebro verific  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1   YES   NO  27. MANNER OF DEATH  1   Netural   S   Pending	rosis ula injuffi	Cilency  Epatient 3 DOA  28b. TiM	QTMER: 4.5 Nursing H E OF 28c. I		PERFC 1 VES	PRMED? 2 TS NO	AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?  1 YES 2 NO
EDICAL	PART II. Other significent condition  Allows scle  Larebro valida  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1   YES 25 NO  27. MANNER OF DEATH  1   Netural 5   Pending	HOSPITAL: 1   Input of 2   ER/Out	Cilence  patient 3 DOA  28b. TIMI NJI  Y — At home, farm, s	26. OTHER: 4. Nursing H IE OF IURY M 1	PLACE OF DEATH (C) ome 8 Residence NJURY AT WORK? YES 2 NO	PERFC 1 YES  neck only one) 8 Other (Specify)	INJURY OCCUP	AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?  1 YES 2 NO
ED BI FRISICIAN. MEDICAL	PART II. Other significent condition  All and a significent condition  All and a significent condition  All and a significent condition  25. WAS CASE REFERRED TO MEDICAL  EXAMINER?  1	HOSPITAL:  1   Inpatient 2   ER/Out  280. OATE OF INJURY (Month, Day, Year)  280. PLACE OF INJUR building, etc. (Spe	Cienta  DOA  28b. TIM INJ  Y — At home, farm, s  wiedge, death occurre	26. OT FER: 4. Nursing H IE OF 26c. I URY M 1 [ street, factory, of	PLACE OF DEATH (C) ome 8 Residence NJURY AT WORK? YES 2 NO fice	PERFC  1 YES  1 YES  5 Other (Specify)  28d. DESCRIBE HOW  28f. LOCATION (Stree-City or Town, State)	INJURY OCCUP  t end Number or	AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?  1 YES 2 NO  RED  Rural Route Number,

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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		1. DECEDENT'S NAME (First, Middle, Last)	F	isch			2. DATE OF DEATH	MY Y	3. TIME OF DEATH
9		4 SOCIAL SECURITY NUMBER 091 26 2728	1 M 2 🗆 F	In yrs. lest birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH	1910	BIRTHPLACE (State or Foreign POLAND
l, 2, 3 should	TOR	96. FACILITY NAME (If not institution, give sti	to Spita	1		ER SPRI		9c. COUNTY	of DEATH
permit. Pages	DIRECTOR		ntgomen		v, town or LOCAT	my, h	d.		10d. INSIDE CITY LIMITS? 1 YES 2 NO
nsit	FUNERAL	100. STREET AND NUMBER				2090		u	N OF WHAT COUNTRY?
21215-0020 If or attending physician. For use as the burial-transit	ΒY	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	If yes, sp	ecity Cuban, Maxica 2 NO Specifi	NIC ORIGIN? (Specify Yern, Puerto Rican, etc.)	s or No 14	RACE — American Indian, Black, White, etc. Specify: WHITE
21 al or for u	PLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Recondary (0-12)	ATION completed)  College (1-4 or 5+)				16b. KIND OF BU		NDUSTRY
on det	COMPLET	17. FATHER'S NAME (First, Middle, Last) MEIR	CHAIM	DOUTHE	MATIO		ME (First, Middle, Maiden		NDUSTRY
MARYL retained by 5 should be notified at	BE	19a. INFORMANT'S NAME (Type/Print)	CHAIM	19b. MAILING	ADDRESS (Street e	TILL	IA BI	EDER	del 20002
fi) as	2	MICHAEL SCHOPE		802	LAMBER	TON DRI	VE, SILV	ER SP	20902 RING, MD .
ORE e 6 may ector. pa		20e, METHOD OF DISPOSITION  **Experience of the property of th	val from State 20b.	PLACE AND DATE OF STREET, Cremetory or of MENUC	ther place!		B / 22 / 93		y or Town, State
BALTIMORE, ter death. Page 6 may be the funeral director, page oval.		21. SIGNATURE OF FUNERAL SERVICE LICE	Buch		TAKC	DMA FUN	CILITY	E INC	AEL, YERUSHAL 254 CARROLL
hours aft ed in by or remo		23. PART I. Enter the disesses, or content of the series o	omplicatione that/caused list only one cause on ea	I the daath. Do n ech line.	ot entar the mo	da of dying, suc	h ss cardiec or resp	iratory srrest	t, Approximate interval Between Onset and Death
760, ad within 24 completely fille cremation.		disesse or condition resulting in death)	ONGES OUE TO (OR AS A	TIVE S	HEART	FAIL	JAN		
687 xecuted and con burial,	NO	Sequentially list conditions,	CORONA		RTERY				į
m # 5 m	RTIFICATION	if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DIABET	25 M	781615	US			
eath certificat attending phy mal Hygiene py, or other	ш	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	<b>ን</b> ፡				
DS, the de: d Ment Injury.	C	PART ii. Other significent conditions	contributing to death bu	ut not resulting i	n the undariying	g ceuse given in	Part i. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS
RECORE w requires that th s been signed by t pt. of Health and 3 shows any In	MEDICA						1 YES 2		MARLABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?
TAL RECOR The law requires that tie has been signed by ate Dept. of Health an							_		1 PES 2 NO
F VITAL SICIAN: The law certificate has I the State Dept , or Item 23	PHYSICIAN:		HOSPITAL:	atient 3 DOA	OTHER:	ACE OF DEATH (Ch	8 Other (Specify)		
OF PHYSIC this cer with th		27. MANNER OF OEATH  1 Maturel 5 Pending	28e. OATE OF INJURY (Month, Day, Year)	28b. TIME	E OF 28c. INJI		28d. DESCRIBE HOW I	NJURY OCCUR	ΕO
TTENDI TTENDI TTOR: A after da	ETED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28s. PLACE OF INJURY building, etc. (Special	— At home, ferm, *	- 1		28f. LOCATION (Street of City or Town, State)		Rural Route Number,
Te DIRI	COMPLE	290. CERTIFIER 1 CERTIFYING PHYSIC	IAN: To the best of my knowle	edge, death occurre	d at the time, date	and place, and due	to the cause(s) and mer	nner sa sisted.	
HOSPITAL FUNERAL Ithin 72	E CO	296. SIGNATURE AND TITUS OF CERTIFIER	On the basis of examination	and/or investigation	n, in my opinion, de	eath occured at the 29c. LICENSE NUN			ause(a) and menner as stated.  IGNED (Month, Day, Year)
Total	TO BE	/del 1/	LIMB			DHO	365		IRCH 20 1993
U		30. NAME AND ADDRESS OF PERSON WHO PETER J. SABIR				Care	200 511.15	2 50-	
		31. DATE FILED (Month, Day, Year) MAR 22 '93	32. REGISTRAR'S SIGNA	ATURE	LLIF AVE	SOITE	30 X 3 (LVE)	SPRIN	16 mp 20902



TO THE HOSPITAL METCHAND STAZE RECORDS, P.O. BOX 68760, TO THE HOSPITAL MARYLAND 21215-0020  TO THE HOSPITAL UNFEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be find within 72 hours after death with the State Dept. of Health and Merital Hyglene prior to burial, cremation, or removal.  IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR STATE REGISTRAR		STATE OF N			TMENT OF	HEALTH AND		YGIENE REG. NO.	93	3 09692	
	1. DECEDENT'S NAME (First,	Middle, Last) BETTY	A. GEI	RTON		2. DATE OF DEAT MONTH MARCH				DAY YEAR		
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. in			st birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF 1 (Month, De	BIRTH		IPLACE (State or Foreign		
	577-03-610	_	1 □ M 2 XX	82	YRS.	7,6		JULY	24,19		DIANA	
œ	9a. FACILITY NAME (II not in HEBREW		treet end number)				OR LOCATION OF DI	EATH		COUNTY OF D		
2	RESIDENCE OF DECEDENT									MONTGO	MERI	
DIRECTOR					10c, CIT	Y, TOWN OR LOC					10d. INSIDE CITY LIMITS?	
	MD. MONTGOMERY  100. STREET AND NUMBER					OKVILLE OI. ZIP CODE		100	a. CITIZEN OF V	1]( YES 2 NO		
FUNERAL	6121 MONTROSE RD.					20852				S.A.		
FUN	11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1	T EVER IN U.S. A	RMED NO	13. WAS DE	CENDENT OF HISPAI	NIC ORIGIN? (S	ipecify Yes or N	to- 14. RACE	E — American Indian, k, White, etc.	
ВУ	1 Never Married 2 3 Divo	75-65	IF YES, GIVE V				S 2 NO Specif		,, 010.)	Speci		
		EDENT'S EDUC		16a. D	ECEDENT'S	USUAL OCCUPAT	ION	16b. Kil	O OF BUSINES	SS/INDUSTRY	MULLIE	
COMPLETED	Elementary/Secondary (0		College (1-4 or 5	*)		work done during reservatived.)						
OMP	12 17. FATHER'S NAME (First, Mi	icicita I not)		F	SSIS!	IAM TWAT	VAGER  18. MOTHER'S NA			IENT ST	TORE	
BE C	HARRY	200, 220,	HOFFMA	AN				ANNAH		PERLING	7	
TO B	19a, INFORMANT'S NAME (7)	vpe/Print)		19	Db. MAILING	ADDRESS (Street	end Number or Rural				a	
-	JANET S.		IBERG		2504	MASON ST., SILVER SPRING, MD. 20902						
ı i	20a. METHOD OF DISPOSITI 1 ☐ Burial 2 1 Crematio 4 ☐ Donation 5 ☐ Other	n 3 🗆 Remo	oval from State	cemetery or	ematory or o	OF DISPOSITION (I		DATE		ON City or To		
	1   Burlai 2 to Cremation 3   Removal from State 4   Donation 5   Other (Specify)   CHAMBERS CREMATORY 3/20   RIVERDALE, MD.  21. SIGNATURE OF FUNERAL SERVICE LICENSEE   22. NAME AND ADDRESS OF FACILITY											
	· MIM	1/1/	ambso	oall N	10009	1 7.7 7.7	CHAMBER	9 00	ртулгр	DATE 1	WD 00727	
	23. PART I. Enter the di	seases, or c	complications that	t caused the d	eath. Do						Approximate	
	IMMEDIATE CAUSE (Fin		List only one cau	ise on each lin	e.						Interval Between	
	disease or condition a. Canding						^	^ -			Onset and Death	
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7		····	DUE FO	OF AS A CONS	TULW CONTENCE O	TONA	ry fa	Div	e	3ne Ale		
TION	resulting in death)  Sequentially list conditi If any, leading to immed	ons, flate	WIY.	OFF AS A CONSE	MP	tem	in fa	liv	malf	Suate		
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH 6LOVE 93 III 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS HOURS 110-12-5579 XX M 2 - F 82 YRS. 11-8-1910 CALIFORNIA Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a STATE 10h COUNT 10d. INSIDE CITY LIMITS? MARYLAND MONTGOMERY 1X YES 2 NO BETHESDA FUNERAL 10e. STREET AND NUMBER 10f, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 4915 **BATTERY LANE #2** 20814 UNITED STATES 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea If yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. If yes, specify Cubs
1 ☐ YES 2 ▼ NO 1 Never Married 2 X M BY Specify. 3 Widowed 4 Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complex 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b, KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) ARTIST-DESIGNER ADVERTISING be notified at once. 17. FATHER'S NAME (First, Middle, Last 18. MOTHER'S NAME (First, Middle, Maiden Surname) KIRK GLOVER STUBELFIELD SUSAN BE THE INFORMANT'S NAME (Type/Print 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 SYLVIA GLOVER 4915 BATTERY LANE #2-BETHESDA, MARYLAND 20814 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stats DATE examiner must etion 2 [ KING DAVID MEMORIAL GARDEN 3/19 FALLS CHURCH, VIRGINIA Other (Specify) DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. due 1170 ROCKVILLE PIKE - ROCKVILLE, MD. 23. PARTA. Enter the disease shock, or head es, or compileations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata fallure. List only one cause on each line. IMMEDIATE CAUSE (FIRM Onset and Death the disease or condition ARKINSON'S resulting in death) marked, or Item 23 shows any injury, or other traumatic event, DUE TO (DR AS A CONSEQUENCE OF) ARKINSONS DISEASE PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 AO 1 TES 2 TANO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: t YES 2 NO 5 Residence 6 Other (Specify) AF Nurs 26s. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investige BY 1 YES 2 NO 2 Accident
3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Routs Number, City or Town, State) COMPLETED 6 Could not be determined 4 Homicide PORTANT: If Item 28 29a. CERTIFIER

16 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as steted. 2 MEDICAL EXAMINER: On the besis of examination snd/or investigation, in my opinion, death occured at the time, date and piece, and due to the cause(s) and menner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 039166 29d. DATE, SIGNED (Month, Day, Year) 17/93 /pres wall 31 9 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 6121 MONTROSE 32. PEGISTRAR'S SIGNATURE
Fruita Davidson Pandalle 31. DATE FILED (Month

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BALTIMORE, MARYLAND 21215-0020

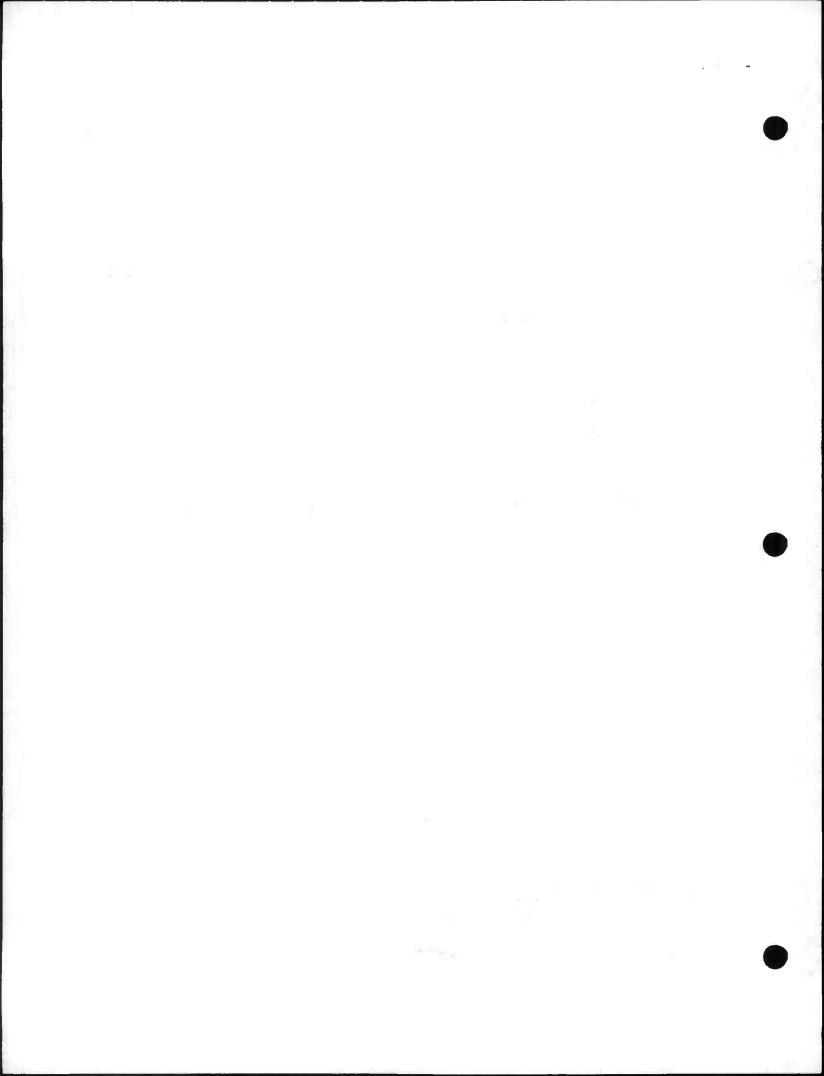
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH DAY 3. TIME OF DEATH YEAR ROBERT GRIFFIN DUANE March 19 1993 11:27 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 2-13-1931 8. BIRTHPLACE (State or Foreig 217-26-4346 1X M 2 - F YRS Pennsylvania 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Maryland General Hospital Baltimore City Baltimore RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore Maryland Baltimore 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 24 South Patterson Park 21231 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? XXX YES 2 ☐ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or NoIf yea, specify Cuben, Mexican, Puerto Rican, etc.)
 U YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1X Never Married 2 Marrie BY 3 Widowed 4 Divorced U.S. Marines White COMPLETED 18s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high ege (1-4 or 5+) dary (0-12) 12 Telemarketer Merchandising 17, FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Joseph H. Griffin Sara Stevenson BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 241 South Broadway, Sharon L. Baseman Baltimore, MD 21231 9 20e METHOD OF DISPOSITION
1 Burlal 2 Cremation 3 Ren
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must Spring Hill Cemetery 3-22 Easton, MD 21601 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Newnam Funeral Home, P.A. JOHN R MERCERON CFSP 200 S. Harrison St. Easton medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final the disease or condition resulting in death) .Empyema right lung event, DUE TO (OR AS A CONSEQUENCE OF): La respiratory failure
DUE TO (OR AS A CONSEQUENCE OF): traumatic MEDICAL CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING bronchopleural fistula CAUSE (Disease or Injury other DUE TO (QR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 any injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO OF DEATH? Shows 1 YES 2 NO PHYSICIAN: Dept. 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 Inpatient 2 ER/Outpatient 3 DOA 1 TYES 2 THO ie 5 - Residence 6 - Other (Specify) 6 27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED is marked, XXX Netural 5 Pending 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 28 4 | Homicide item 29a. CERTIFIER (Check only one)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s). 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Interval Between Onset and Death 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE 29d. DATE SIGNED (Month, Day, Year) 29¢ LICENSE NUMBER BE P64-3 93 N/A n 9 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ARNOU MD GEN -MOSP. BELEN 32. REGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year) in Savidson But MAR 2 2 1993



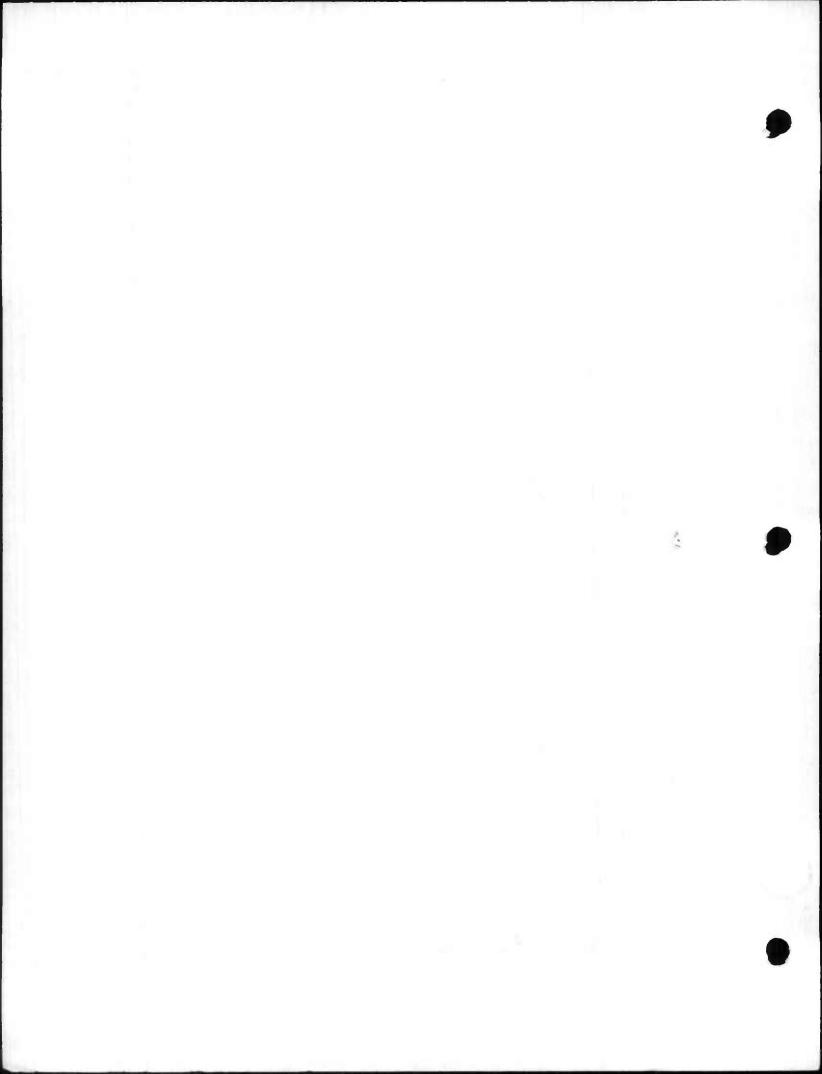
DIVISION OF VITAL RECORDS, P.O. BOX 687	A STATE OF THE PERSON OF THE P
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REC	Section .
TAL	-
OF V	NAME OF ASSESSED
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TO BE COMPLETED BY FUNERAL DIRECTOR	medical examiner must be notified at once.	ils certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should hit he State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the filter with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

31. DATE FILED (Month, Day, Year)
MAR 22 '93

32. REGISTRAR'S SIGNATURE
Julia Davidson-Rondall

	FOR 1 - STATE REGISTRAR	STATE OF MARYL		MENT OF H		NTAL HYGIEN	_	33 0969	95	
	1. DECEDENT'S NAME (First, Middle, Last)		raha	m	2.	DATE OF DEATH DI	20 8	3. TIME OF DEATH 0458	A M	
	579 01 3367	☐ M 2💢 F	83 YRS.	F UNDER 1 YEAR	HOURS MIN. SE	Month, Day, Year)	1909	BIRTHPLACE (State or Foreign NEW YORK	gn	
TOR	96. FACILITY NAME (If not institution, give street WASHINGTON ADVE! RESIDENCE OF DECEMENT		A PARK		9c. COUNTY	OF DEATH ONTGOMERY				
DIRECTOR		MD 106. CQUATY MONTGOMERY 106. CITY, TOWN OR LOCATION TAKOMA PA						10d. INSIDE CITY LIMITS? 1 YES 2 NO	)	
FUNERAL	309 ETHAN VALLEN	101	20912		-	S.A.				
BY	11. MARITAL STATUS  12 Never Married 2 Married  3 Wildowed 4 Divorced	FORCES? 1 YES  FYES, GIVE WAR OR DO  ARMY	2 NO	If yes, spe	ENDENT OF HISPANIC Colorly Cuban, Mexican, Pi 2 NO Specify:	PRIGIN? (Specify Yes verto Ricen, etc.)	or No.— 14.	RACE — American Indian, Black, White, etc. Specify: WHITI	Ε	
COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade continued to the contin	PON (college (1-4 or 5+) FOUR	life. Do NOT use	rk done during mo	st of working	166. KIND OF BUS	OFF I			
CON	17. FATHER'S NAME (First, Middle, Last)	TOOK	DEGAD	DECKE.	18. MOTHER'S NAME (			CE		
BE	LYMAN  19a. INFORMANT'S NAME (Type/Print)	W	GRAI	THE RESERVE AND ADDRESS OF THE PARTY OF THE	BERT			MABEL		
5	JUANITA HODDE		19b. MaiLING ADDRESS (Street and Number or Rural Route Number, City or Town  104 PARK AVE., TAKOMA PAI							
	20s. METHOD OF DISPOSITION 11 Burial 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	from State 20b	PLACE AND DATE OF	DISPOSITION (Na	me of	OATE 20c. LO	CATION — City	or Town, Stets EPHI, MD.		
	21. SIGNATURE OF PUNERAL SERVICE LICENS	Bul		22. NAME AN TAI N. V	OMAI FUNE  V. WASHIN	RAL HO	ME 25	4 CARROLL 20012	ST	
	23. PART I. Enter the diseases, or comshock, or heert fellure. List IMMEDIATE CAUSE (Finel disease or condition resulting in death)	Card	ech line.	t enter the mo	the of dying, such sa	cardlec or respi	ratory arrest	Approximate interval Betwoonset and D	veeп	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST									
PHYSICIAN: MEDICAL CI	PART II. Other algorificent conditions of Bulatural	ontributing to deeth b	ut not resulting in	the underlying	ceuse given in Peri	1. 24a, WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDI AMALABLE PRIOR TO COMPLETION OF CAUS DF DEATH? 1 YES 2 NO		
SICIAN		OSPITAL:		OTHER:	ACE OF DEATH (Check o					
PH	27. MANNER OF DEATH  1 1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME	NOI WO	RK?	I. DESCRIBE HOW II	JURY OCCUR	EO		
TED BY	2 Accident Investigation 3 Suicide 8 Could not be detarmined    8 Could not be detarmined    1 YES 2 NO  28a. PLACE OF INJURY — At home, ferm, etraet, factory, office    28a. PLACE OF INJURY — At home, ferm, etraet, factory, office					. LOCATION (Street a City or Town, State)	and Number or F	iural Route Number,		
COMPLETED		t: To the beet of my knowl						use(a) and manner as state	d.	
TO BE C	296/ SIGNATURE AND TITLE OF CERTIFIER  30. NAME AND ADDRESS OF PERSON WHO CO	DH274	142741 March 20, 199.							
		BELLON,	116	WASI	HING TO A	1, De	201	709		



BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

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IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	IMP
be filed within the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	pe fil
TO THE FIRMS CONFIRM After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detact	101
TO THE HIRTHY OF THE DING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the ho	101
DIVINON OF VITAL RECORDS, P.O. BOX 68760,	5
(	1

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

													93	096	96
FOR STATE REGISTRAR		STATE OF N	IARYL	AND /	DEPART	CATE (	F H	EALTH AND I	MEN		GIEN	E		0 2 0	
1. DECEDENT'S NAME (First, MIDDE MARGAR	ET	Margaret	V.	Gia	rdina DIN	A				ATE OF DI	EATH DA	¥ -	1902	3. TIME OF DEA	NTH N
4. SOCIAL SECURITY NUMBER 246-07-0185		5. SEX 1  M 2  F	6. AGE (/	(In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7 7 YRS. MONTHS DAYS HOURS MIN.				7. DATE OF BIRTH (Month, Day, Year) 1/07/16			BIRTNPLACE (State or Foreign Country)				
•a. FACILITY NAME (If not Institution, give atreet and number) Washington Adventist Hospital							R LOCATION OF DE		7017	10	9c. COL	INO I	th Caro	olina	
RESIDENCE OF DECEDE		ist nosp	ıtaı			Ta.	KOI	na Park				Mo	ntgon	nery	
Maryland 10b.	Prin	nce Georg	ges			town or t elphi	OCAT	ION						10d. INSIDE CIT LIMITS?	
10e. STREET AND NUMBER							101	ZIP CODE				10g. CIT	IZEN OF W	WHAT COUNTRY?	
9305 20th. A	ve.						2	20783				П	S.A.		
11. MARITAL STATUS  1 Never Married 2 Married  1 Never Married 2 Married  3 Wildowed 4 Divorced  12. WAS DECEDENT EVER IN FORCES? 1 YES				2 👿 N		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— 14. RACE If yes, specify Cuban, Mexican, Puerto Rican, etc.)					American ind t, Whita, etc.	len,			
15. DECEDEN (Specify only higher	T'S EDUC	ATION completed)		16a. DEC	CEDENT'S U	SUAL OCCU	PATIC	N at al working		16b. KIND	OF BUS	INESS/IN	DUSTRY		
Elementary/Secondary (0-12)		College (1-4 or 5 +	)	(Give kind of work done during most of working life. Do NOT use netword.)  Homemaker											
17. FATHER'S NAME (First, Middle, I Dock Lester		ing						18. MOTHER'S NAI			Maiden :	Surname)			
19s. INFORMANT'S NAME (Type/Pri				19b	MAILINO	ADDRESS (St	reet a	nd Number or Rural F			y or Town	, State, Zij	p Code)		
Joseph F. Giar	dina			5	205 C	aroli	ne	Circle	Wa	ldor	f.M.	arv1	and 2	20601	
20s. METHOD OF DISPOSITION 1 ☐ Burlel 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other (Speci	Remo	val from Stats	ceme	stery, cren	ND DATE OF	er place)		me of 20/93			20c. LOC	CATION -	City or To		d
21. SIGNATURE OF FUNERAL SER	VICE LICE	Poller	8			22. NAN	E ÁN	New Ham		Hine	s-R	inal	di F	uneral	Home
23. PART I. Enter the disease shock, or heert f	es, or co	ortplications that	ceused	the dea	ith. Do no									Approxim	nste
tMMEDIATE CAUSE (Finel disease or condition resulting in death)		5	EP	71		MIME	4							Onset an	
Sequentially list conditions, if any, leading to immediate	<b>•</b>	DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  CELEBRO VASCULAR ACCIDENT													
cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted events	٠ }	DUE TO	AF OR AS A	BA (	UENCE OF				CC	101	300	T		+	
resulting in desth) LAST	d.	DI A BETES MELLITIS													

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATN (Check only one) HOSPITAL: OTHER: 1 YES 2 NO ng Nome 5 - Residence 6 - Other (Specify) 26s. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF INJURY 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Netural

Accident 5 Pending Investigation M 1 YES 2 NO 28s. PLACE OF INJURY — At home, larm, street, factory, office building, etc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be determined 4 Homicide

29s. CERTIFIER (Check only CERTIFYINO PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

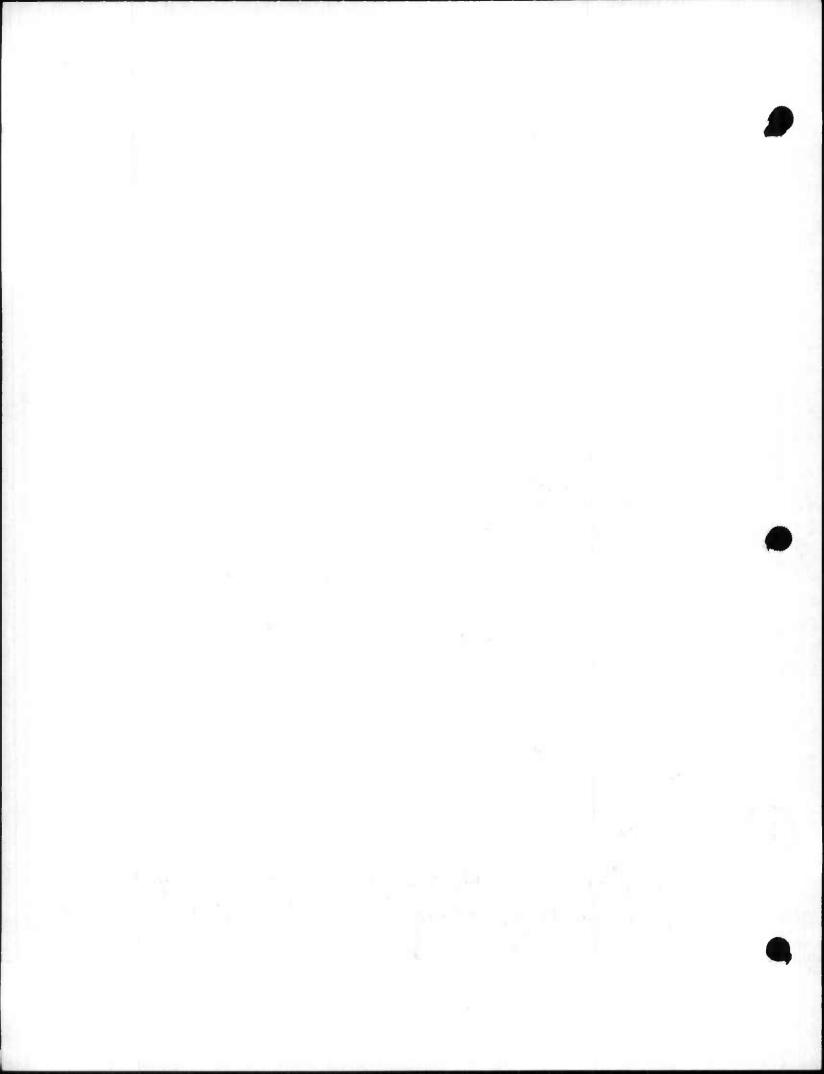
PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i.

MEDICAL EXAMINER: On the basis of exigation, in my opinion, death occured at the time, dats and placs, and dus to the cause(s) and manner ee stated

24s. WAS AN AUTOPSY PERFORMEO?

29b, SIGNATURE AND THILE OF CERTIFIER	Attend Phys	29c. LICENSE NUMBER  0 19 89 7	29d. DATE SIGNEO (Month, Day, Year)
30. NAME AND ADDRESS OF PERSON WHO COMPLETED	HARDVAL PAUK	WAY Granbell 1	nd 207 70

31. DATE FILED (Month, Day, MAR 22 32. REGISTRAR'S SIGNATURE
Juha Davidson Mandale '93



BALTIMORE, MARYLAND 21215-0020	sath. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Merital Hyglene prior to burial, cremation, or removal.	aminer must be notified at once.
N OF VITAL RECORDS, P.O. BOX 68760, BALTI	G PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	er this certificate has been signed by the attending physician and completely filled in by the funeral ath with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal.	narked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,
DIVISIO	R ATTEND	DIRECTOR: A	Item 28 Is
(	HE HOSPITAL	The Author 72	PORTANT: II
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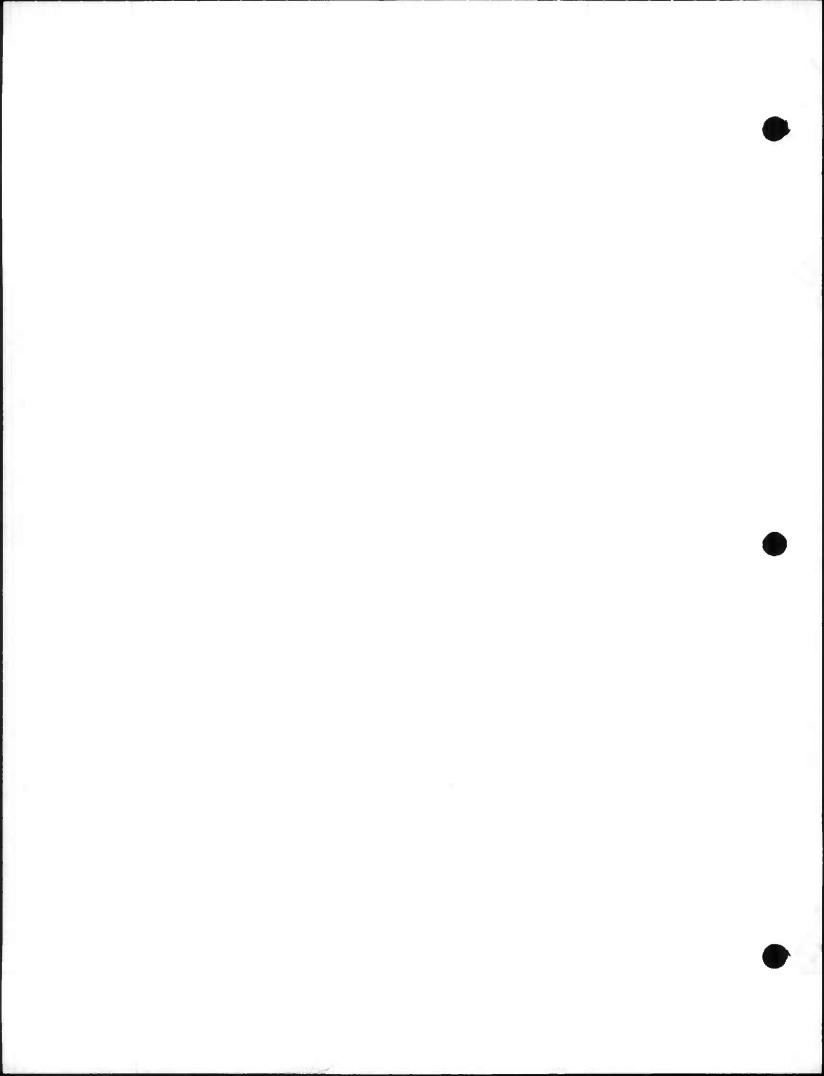
DE TIES

	FOR 1 - STATE REGISTRAR	STATE OF N			ITMENT				MENTAL HYGIE REG. N	145	93	0969	7
	Laura M. Gallagher								2. DATE OF DEATH	DAY	1993	3. TIME OF DEATH  1:55 p	
)	4. SOCIAL SECURITY NUMBER 706-12-9052	5. SEX	□ M 2 □ F 84 YRS. MO					F UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year)			8. BIRTHPLACE (State or Foreign Country) NEW YORK		
TOR	9a. FACILITY NAME (If not institution, give as Montgomery Ger RESIDENCE OF DECEDENT		ospital	L		lne	OR LOCATI	ON OF DE	ATH		itgor		
- DIRECTOR	Property life in the control of the				Y, TOWN C	ER S	SPRIN					10d. INSIDE CITY LIMITS? 1 YES 2 N	0
FUNERAL	100. STREET AND NUMBER  15121 GLADE DRIVE #3B						. ZIP COD	2090			USA	VHAT COUNTRY?	
BY	11. MARITAL STATUS  1 Never Married 2 Married  3 Wildowed 4 Divorced  12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES					13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify,Cuban, Mexican, Puerto Rican, etc.)  1  YES 2 ANO Specify:					Speci	14. RACE — American Indian, Black, White, etc. Specify: WHITE	
COMPLETED	(Specify only highest grade completed)  (Give kind of life. Do NOT lif					'S USUAL OCCUPATION downward working use retired.)  MAKER							
BE CON	17. FATHER'S NAME (First, Middle, Last)  JOHN J. MURRAY					18. MOTHER'S NAME (First, Middle, Maiden Surname)  ELIZABETH C. SMITH							
6	190. INFORMANT'S NAME (Type/Print)  JOHN J. GALLAGHER	(HUSB			AALING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  21 GLADE DRIVE #3B SILVER SPRING, MARYLA					YLAND 209	906		
	20a. METHOD OF DISPOSITION  DESCRIPTION 3 Remarks Proceedings of the Communication 1 Remarks Proceedings of the Communication of the Co		20b. PLACE A cometery, cree GATE	maton, or o	ther place)	N CE	METE	RY	3/20 SIL		City of To		ND
	21. SIGNATURE OF FUNERAL SERVICE LIC	illens	$\mathcal{D}$		FR.	ANCI O UN	IVER	COL SITY	LINS FUNE BLVD., W.	SIL.	SPR.		1
	23. PART I. Enter the disease, or o shock, or heart failure. IMMEDIATE CAUSE (Finel	List only one ceu	se on each line							piratory a	rrest,	Approximate interval Better Onset and I	Ween
	disease or condition resulting in death)	DUE TO	OR AS A CONSEC	WENCE O	F):							IHR.	
ATION	Sequentially flat conditions, if any, leading to immediate	DUE TO	OR AS A CONSEC	UENCE O	F):				ASE			5 YR.	-

MEDICAL CERTIFICATION HEART DEJEA CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? EMPHYSEMA 1 TYES 2 PNO OF DEATH? 1 - YES 2 - NO BY PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF OEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER:
4 Nursing Home 5 Residence 8 Other (Specify) 1 YES 2 NO 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending
2 Accident Investigation M 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be determined BE COMPLETED 4 Homicide 29a. CERTIFIER (Check only one)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated.

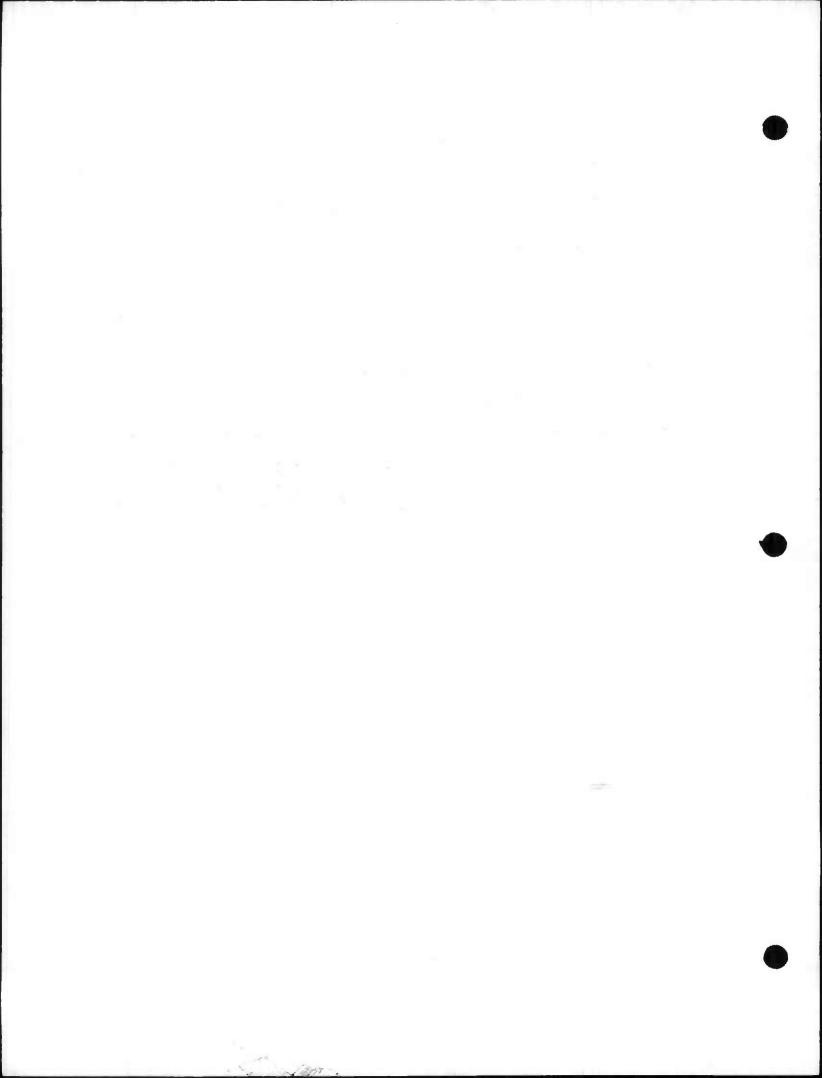
2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the tima, date end place, end due to the cause(e) end manner es stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 2-29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 023630 3-17-93 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANK J. MAYO, MD 16220 #213, RO Frederick boithersburg, MO 20877 31. DATE FILED (Month, Day, Year)
MAR 22 '93 3. REGISTBAR'S SIGNATURE



B.K.S

ITEMS: 23 PART I, 27, 28a-f, PER MEO G-698 4/8/93 t.t 93 09698

	1 - STATE REGISTRAR	STATE OF MARYLAN	ID / DEPARTM	ENT OF H	EALTH AND DEATH	MENTA	L HYGIENI	E 91	3 (	19698	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE	OF DEATH		EAR 3.	TIME OF DEATH	
	DAVID	WILLIA		GAI	NES	03	02	93	9	:50 A	
	4. SOCIAL SECURITY NUMBER 212-82-6960	-	MON	THS DAYS	HOURS MIN.	(Monti	OF BIRTH		Country)	ACE (State or Foreign	
	\$a. FACILITY NAME (If not institution, give str			CITY, TOWN O	OR LOCATION OF D	May	14,1	967 I			
CTOR	LAKE LANDING RD				ersbur			MONT			
DIRE	106. STATE 106. COUNTY		10c. CITY, TO	WN OR LOCAT	ION				100	d. INSIDE CITY LIMITS?	
	Maryland Montg	omery	Ga		sburg					XYES 2 NO	
FUNERAL		n Ash Way,		101.	20879				S.A	T COUNTRY?	
3	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.	S. ARMED	13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN	? (Specify Yes		RACE -	American Indian.	
BY F	1 X Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES 2 IF YES, GIVE WAR OR DATE:			2 XNO Speci		ticen, atc.)	Black, White, atc. Specify:			
	15. DECEDENT'S EDUC	ATION 46	A COCUMATIO		1		1	Bla	.ck		
ETE	(Specify only highest grade of Elementery/Secondary (0-12)		(Give kind of work of life, Do NOT use retir	ione durina mos	st of working	166	KIND OF BUS	INESS/INDUS	TRY		
once. COMPL	12 Grade		Data P	roces	sor		No	ne			
COM	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, I	fiddle, Maiden S	Surname)			
ed at	Robert W.					elyn		ker			
TO BE	190. INFORMANT'S NAME (Type/Print) ( Mrs Evelyn Gain	Mother)							State, Zip Code) 20879 thersburg, Md		
8	20a METHOD OF DISPOSITION	20h BI	ACEAND DATE OF DIS			n wa		ATION - City			
must	1   Burial 2   Cremation 3   Remote 4   Donation 8   Other (Specify)		y, crematory or other pl Metropol	ace!		1		xandr			
examiner	21. SIGNATURE OF FUNERAL SERVICE UCI	MSEE	THE CLOSE	22. NAME AN	den Fu						
	Singe K	· / monde	-	246	N. Was	hing	ton S	t, Ro	ockv	rille, M	
ry, or other traumatic event, the medical CERTIFICATION	23. PART I. Enter the disease, or co- ahock, or heart failure. L  IMMEDIATE CAUSE (Finel disease or condition resulting in death)  Sequentially list conditions, if erry, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	ACUTE ETHANOL  ASSOCIATED  DUE TO (OR AS A CO  DUE TO (OR AS A CO	AND PHEN WITH DROW  INSECUENCE OF):	ICYCLII						interval Betwee	
MEDICAL	PART II. Other algnificent conditions	contributing to death but r	not resulting in the	e underlying	ceuse given in	Part I.	24a. WAS AN A PERFORM	MED?	AMA COI OF	RE AUTOPSY FINDING NLABLE PRIOR TO MPLETION OF CAUSE DEATH?  YES 2 NO	
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	OTI	HED.	ACE OF DEATH (C)						
의 수 [	27. MANNER OF DEATH	1 ☐ Inpatient 2 ☐ ER/Outpatien 28s. DATE OF INJURY	mt 3 🗆 DOA   4 🗆	Nursing Home	5 Residence					ATER	
	1 Netural Statemoling	(Month, Day, Year)	3 9:50 A	28c. INJU WOF 1 Y	ES 2 V NO		NOWN	JURY OCCUR	EO		
<u>∞</u>   □	3 Suicide 8 CCould not be	28s. PLACE OF INJURY — I building, etc. (Specify)	J - J O N			28f, LOC/	TION (Street at	nd Number or I	Runal Route	Number,	
ETE	4 Homicide detarmined	FOUND: POND				Walk	er's C	hoice	Road	ng Road/ d	
튀 로		IAN: To the best of my knowledge									
IMPORTANT: If its	2 X MEDICAL EXAMINER	On the basis of examination an	d/or investigation, in	my opinion, de	eath occured at the	time, date	and place, and	dua to the co	ause(a) and	d menner as stated.	
BE	296. SIGNATURE AND TYPLE OF CERTIFIER	1000	. 0		29c. LICENSE NUI	MBER				rith, Day, Year)	
일	30. NAME AND ADDRESS OF PERSON WHO		(ITEM 27) (Young Dring)		OCME	_		▶03	- 03	3 - 199	
		U SERIII		ENN S	STREET	BALT	'IM^RF	E.MAR	YLAN	ND 2120:	
	31. DATE FILED , I, Day, Year)	32. REGISTRAR'S SIGNATUR	DE .					,			
	MAR (15 193	Julia Davidson	-April 182								



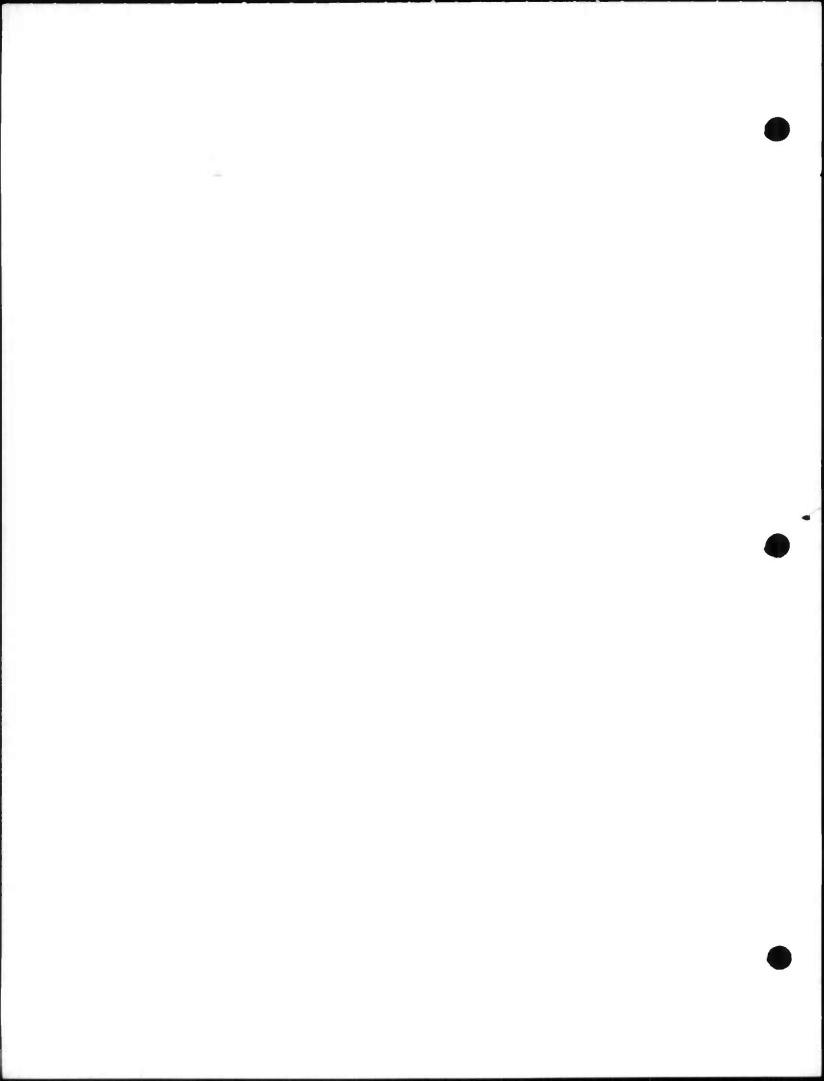
BALTIMORE, MARYLAND 21215-0020

WISION OF VITAL RECORDS, P.O. BOX 68760,

31. DATE FILED (Month, Day, Year)
MAR 23 93

32. BEGISTRAR'S SIGNATURE

					REG. NO		_				
1. DECEDENT'S NAME (First, Middle, Lust)  ELTZARETH ROSE N	MADIE COOK IIA	מרטיזיי			2. DATE OF DEATH	DAY	YEAR	3. TIME OF DEAT			
		TAR   T   100000 00000				4:30					
010 00 1551		YRS.			DEC - 1		Country,				
9a. FACILITY NAME (If not institution, give stre			9b. CITY, TO	OWN OR LOCATION OF I							
MANOR CARE _ SIL	VER SPRING		SIL	VER SPRING							
RESIDENCE OF DECEDENT											
MARYLAND PRIN	ICE GEORGES							10d. INSIDE CITY LIMITS?			
10a. STREET AND NUMBER				101. ZIP CODE		10g. CITIZ		1 YES 2 HAT COUNTRY?			
12007 BLAKETON S	TREET			207	72						
	12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2	ARMED	13. WAS	S DECENDENT OF HISP	NIC ORIGIN? (Specify Y		14. RACE	- American India White, atc.			
3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES					Ī	Specify				
15. DECEDENT'S EDUCA	TION 16a.	DECEDENT'S	USUAL OCCU	JPATION	16b, KIND OF BL	JSINESS/INDU	ISTRY	WHITE			
		(Give kind of v life. Do NOT us	vork done durir se retired.)	ng most of working							
12	H	OMEMAK	ER_								
	COOK					n Surname)					
19a. INFORMANT'S NAME (Type/Print)	COOK	19b. MAILING	ADDRESS (St								
J. GLENN HARWOOD						,	,				
20g. METHOD OF DISPOSITION	20b. PLA6	CE AND DATE O	FDISPOSITIO				_				
4 Donation 5 Other (Specify)	ST.	ROSE	OF LIM	IA CEMETER	7 3/23 GAT	THERSE	IIRG.	MD			
21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE TO A	2	22. NA	ME AND ADDRESS OF F	ACILITY		,				
Varnel	H. Kall		buu	UNIVERSIT	Y BLVD., W	. SIL	SP	INC.			
23. PART i. Enter the diseases, pr con shock, or heart failure. Lie	mplications that ceused the It Only Dne ceuse on eech i	deeth. Do n	Dt enter the	e mode of dying, su	ch as cerdiec or resp	oiratory arre	st,	Approxima			
IMMEDIATE CAUSE (Finel disease or condition	Da .	0 00	1	1.1.0				Onset and			
disease or condition resulting in death)  s. Pneumonu, left ower lobe  Due to (or as a consequence of):  Inferior myo condition.  Sequentially list conditions.											
	Inbevor m	ction			3 1419						
	DUE TO (OR AS A CON	SEQUENCE OF	7:	4				2000			
CAUSE (Disease or injury C.	DUE TO OD AS A COM	SEQUENCE OF						1			
resulting in death) LAST	DOE TO (OR AS A CONS	SECUENCE OF	-):								
DANT II Other death								1			
Donoth Annoth							1	WERE AUTOPSY FIF			
Thousand Figure	supportion	N 77	ernpo	riwiypac	1 - YES	2)X NO		COMPLETION OF C OF DEATH?			
Distribuy Intal	ingection						1	YES 2 N			
25. WAS CASE REFERRED TO MEDICAL			2	6. PLACE OF DEATH (C	heck only one)						
. m		3 DOA	OTHER: 4 Nursing	Home 5 - Residence	8 Other (Specify)						
27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)		E OF 280			INJURY OCCU	RED				
2 Accident Investigation											
3 Suicide 6 Could not be 4 Homicide detarmined	26s. PLACE OF INJURY — At building, atc. (Specify)	home, farm, s	treet, factory,	offica	26f. LOCATION (Street City or Town, State	and Number or	r Rural Roo	ute Number,			
29a. CERTIFIER CERTIFYING BUYGO	N. To the head of the head										
								and manner as et			
296 SIGNATURE AND TITLE OF CENTIFIED	7 10	0	111112-1111								
1111111 1 11111111	(1//	1 0001		THE EIGENSE NO	MDER	290. DATE :	SIGNED (4	wonth, Day, Year)			
	4. SOCIAL SECURITY NUMBER 213-28-1554  9a. FACILITY NAME (If not institution, give streem of the content of the	4. SOCIAL SECURITY NUMBER 213-28-1554  9a. FACILITY NAME (If not institution, give street and number)  MANOR CARE SILVER SPRING  RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY  MARYLAND PRINCE GEORGES  11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. FORCES? 11. VES. QIVE WAR OR DATES  15b. DECEDENT'S EDUCATION 15b. DECEDENT'S EDUCATION 15b. DECEDENT'S EDUCATION 15c. DECEDENT'S EDUCATION 15c. DECEDENT'S EDUCATION 15c. DECEDENT'S EDUCATION 15c. DECEDENT'S EDUCATION 15d. DECEDENT'S EDUCATION 15d. DECEDENT'S EDUCATION 15d. DECEDENT'S EDUCATION 15d. DECEDENT'S EDUCATION 15d. DECEDENT'S EDUCATION 15d. DECEDENT'S EDUCATION 15d. DECEDENT'S EDUCATION 15d. DECEDENT'S EDUCATION 15d. DECEDENT'S EDUCATION 15d. DECEDENT'S EDUCATION 15d. DECEDENT'S EDUCATION 15d. DECEDENT'S EDUCATION 15d. DECEDENT'S EDUCATION 15d. DECEDENT'S EDUCATION 15d. DECEDENT'S EDUCATION 15d. DECEDENT SEVICE OCCUPATION 15d. DECEDENT'S EDUCATION 15d. DECEDENT'S EDUCATION 15d. DECEDENT'S EDUCATION 15d. DECEDENT SEVICE OCCUPATION	4. SOCIAL SECURITY NUMBER 213-28-1554  9a. FACILITY NAME (In an institution, give street and number)  MANOR CARE SILVER SPRING  RESIDENCE OF DECEDENT  10b. COUNTY  MARYLAND PRINCE GEORGES  11. MARITAL STATE 11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 12. WAS DECEDENT EVER IN U.S. ARMED 13. Widowed 4 (M) Divorced  14. DECEDENT'S EDUCATION (Specify only highest grade completed) Elamentary/Secondary (6-12) CHARLES COOK  15. DECEDENT'S EDUCATION (Specify only highest grade completed) CHARLES COOK  15. ADECEDENT'S EDUCATION (Specify only highest grade completed) CHARLES COOK  15. ADECEDENT'S EDUCATION (Specify only highest grade completed) CHARLES COOK  15. ADECEDENT'S COOK  16. AGE (In yrs. least britidaly, 184 FYES, GIVE WAR OR DATES  16. AGE (In yrs. least britidaly) 16. CAT 16. OR STREET 17. AND DECEDENT EVER IN U.S. ARMED 18. DECEDENT STREET 18. ADECEDENT'S COOK 19. ADECE	4. SOCIAL SECURITY NUMBER 213-28-1554  5. SEX 1	4. SOCIAL SECURITY NUMBER  2 13 - 28 - 1554  18. TABLITY NAME (If not institution, give sines and number)  MANOR CARE  SILVER SPRING  SILVER SPRING  SILVER SPRING  SILVER SPRING  SILVER SPRING  SILVER SPRING  SILVER SPRING  100. CITY, TOWN OR LOCATION OF A STATE OF THE SPRING OF TH	ELIZABETH ROSE MARIE COOK HARWOOD  4. SOCIAL SECURITY NUMBER  12. 3- 25	ELIZABETH ROSE MARIE COOK HARWOOD  4. SOCIAL SECURITY MUMBER  5. SEX   S. AGE (PRY 16 brindly)   FUNCIN 1 VAR.	ELIZABETH ROSE MARIE COOK HARWOOD  4. SOCIAL SECONTY NUMBER  5. SEX 19 x 20 x 1 x 20 x 20			



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DIVISION OF VITAL RECOKEDS, P.C. BOX GOLOG.

THE HOSPITAL OF ATTENDING PHYSCIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

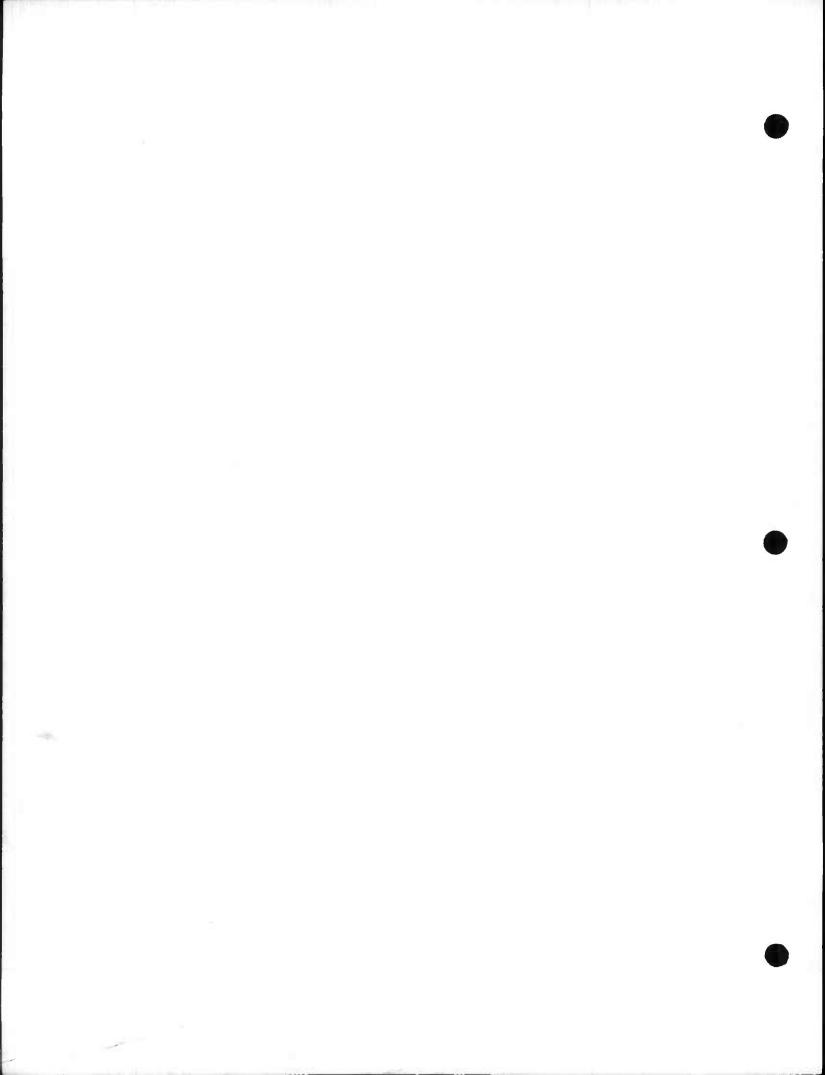
DIVENIENT CHARTER OF THE COMPLETE HE has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be different and the state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

\*\*\*INTERPRETATION OF HEALTH STATE OF THE MENTAL HE

							9 :	3 19711			
	1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	TMENT OF HEA	ALTH AND	MENTAL HYGIE		0 0 0 1 0 0			
	1. DECEDENT'S NAME (First, Middle, Lest)	TROY COME			LAIII	2. DATE OF DEATH	<u>.                                    </u>	3. TIME OF DEATH			
	Trov C.	Hubbard		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		MONTH 3	18 - 9"	2 10:45 AM			
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In	yrs. lest birthday)	IF UNDER 1 YEAR	UNDER 24 HRS.	7. DATE OF BIRTH	0	BIRTHPLACE (State or Foreign			
	212-10-2727	1 <del>X</del> M 2 □ F 88	YRS.	MONTHS DAYS H	DURS MIN.	JAN. 13,		Country)			
	Sa. FACILITY NAME (If not institution, give str	11 00		9b. CITY, TOWN OR L	OCATION OF D						
Œ	HOLY CROSS H	HOSPITAL									
18	RESIDENCE OF DECEDENT	IOSTITAL		SILVER	SPRING		MONTG	OMERY			
DIRECTOR	10a. STATE 10b. COUNTY		10c. CITY	, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?			
	MARYLAND MONT	GOMERY	SIL	VER SPRI	NG			1 YES 2 NO			
¥	10e. STREET AND NUMBER			10f. ZII	CODE		10g. CITIZEN	OF WHAT COUNTRY?			
5	11633 LOCKWOOD	DRIVE, #10	1		2090	4	USA				
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER IN I	U.S. ARMED			IC ORIGIN? (Specify		RACE - American Indian.			
BY F	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DAT	ZNO		NO Specif	n, Puerto Rican, etc.)		Black, White, etc. Specify:			
	A				Λ			WHITE			
日田	15. DECEDENT'S EDUC. (Specify only highest grade of	completed)	(Give kind of w	USUAL OCCUPATION ork done during most of	f working	16b. KIND OF B	USINESS/INOUS	TRY			
1 5	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	,							
COMPLETED	12		SALES M	ANAGER				NGER ALE			
						ME (First, Middle, Malde	on Surname)				
BE	WILLIAM A.	HUBBARD			EMMA	J.					
2	19a. INFORMANT'S NAME (Type/Print)			ADDRESS (Street and I				de)			
8	JAMES W. HUBBA			GALLERY C							
	20a. METHOD OF DISPOSITION 1 Department of Disposition 3 December	20b.F	PLACE AND DATE O	FDISPOSITION (Name of	of		OCATION — City	or Town, State			
	4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LUOR	IMET	ROPOLIT	AN CREMAT			EXANDRI	A, VA			
a regulation		11.111.0	-	FRANCIS	J. COLI	LINS FUNE	RAL HOM	E. TNC			
	Marks.	pelele		AIND OOK	ERSITY	BLVD., W.	, SIL.	SP., MD 20901			
	23. PART I. Enter the diseases, or co	omplications that ceused	the deeth. Do n	ot enter the mode	of dying, suc	h es cardiac or ree	piratory arrest				
	shock, or heart fellure. List only one ceuse on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Due TO (or As A consequence of):  Myo caudial Infanction -  Due TO/(or As A consequence of):  Due TO/(or As A consequence of):  Cause. Enter UNDERLYING  CAUSE (Disease or injury.										
	disease or condition resulting in death)	Respir	along	tailme							
		DUE TO (OR AS A C	CONSEQUENCE OF	): T	1.						
N	Sequentially list conditions, b.	Myoca	ndhal	Intan	chon						
RTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	DUE TO/(OR AS A C	CONSEQUENCE OF	):	L [	J 1					
	CAUSE (Disease or injury C.	DUE TO (OR AS A C	zestive	7 17 20	wr 1	ai me.					
E	that initiated events resulting in death) LAST	DUE TO (OH AS A C	CONSEQUENCE OF	):							
	d.	J									
	PART II. Other aignificant conditions	contributing to deeth but	t not resulting is	n the underlying ce	use given in		N AUTOPSY	24b. WERE AUTOPSY FINDINGS			
	· peep	vern oh	w omb	7875 -		1 _ YES	ORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE			
MEDICAL	Melano	me -						OF DEATH?  1  YES 2 NO			
z											
4	25. WAS CASE REFERRED TO MEDICAL			26. PLACE	OF DEATH (Ch	ack only one)					
15	25. Was Case Reference to Medical EXAMINER?  1 YES 2 NO  28. PLACE OF DEATH (Check only one)  28. PLACE OF DEATH (Check only one)  4 Nursing Home 5 Residence 6 Other (Specify)										
SICI			26b. TIME			28d. DEŞCRIBE HOW	INJURY OCCUR	ED			
PHYSICI	1 YES 2 NO 27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)									
3Y PHYSICIAN:	1 TES 2 NO	26s. DATE OF INJURY (Month, Day, Year)	INJU		2 NO						
B∖	1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation 3 Suicide 6 Could not be		- At home, term, st	M 1 TYES	2 NO	28f. LOCATION (Stree City or Town, Stat	t and Number or F	Rurel Route Number,			
B∖	1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)  26s. PLACE OF INJURY —	- At home, term, st	M 1 TYES	2 NO	28f. LOCATION (Stree City or Town, Stat	t and Number or F	Rural Route Number,			
B∖	1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5 Pending Investigation  2 Accident Investigation  3 Suicide 6 Could not be detarmined  29a. CERTIFIER (Check only)	(Month, Day, Year)  26s. PLACE OF INJURY —	At home, term, st	M 1 VES		City or Town, Stat	9)	Rural Route Number,			
B∖	1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5 Pending Investigation  2 Accident Investigation  3 Suicide 6 Could not be detarmined  29a. CERTIFIER (Check only)	(Month, Day, Year)  26a. PLACE OF INJURY — building, etc. (Specify	At home, term, st	M 1 YES	place, and dua	City or Town, State to the cause(s) and m	enner as stated.				
E COMPLETED BY	1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation  2 Accident Investigation  3 Suicide 6 Could not be detarmined  29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:  29b. SIGNATURE AND TITLE OF CERTIFIER	(Month, Day, Year)  26a. PLACE OF INJURY – building, etc. (Specif)  CIAN: To the best of my knowled  1: On the basis of examination of	At home, term, st	M 1 VES  treet, factory, offica  d at the time, data and in, in my opinion, death	place, and dua	to the cause(s) and m	enner as stated.				
BE COMPLETED BY	1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation 2 Accident Could not be detarmined  29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:	(Month, Day, Year)  26a. PLACE OF INJURY – building, etc. (Specif)  CIAN: To the best of my knowled  1: On the basis of examination of	At home, term, st	M 1 VES  treet, factory, offica  d at the time, data and in, in my opinion, death	place, and dua	City or Town, State to the cause(s) and m time, data and place, IBER	enner as stated, and due to the co	ruse(s) end manner as stated.			
E COMPLETED BY	1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation  2 Accident Investigation  3 Suicide 6 Could not be detarmined  29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:  29b. SIGNATURE AND TITLE OF CERTIFIER	(Month, Day, Year)  26a. PLACE OF INJURY – building, etc. (Specif)  Clan: To the best of my knowled  3: On the basis of examination of examination of the basis of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examin	At home, term, si	M 1 VES  treet, factory, offica  d at the time, data and h, in my opinion, death	place, and dua occured at the c. LICENSE NUM D 3 7	City or Town, State to the cause(s) and m time, data and place, IBER	anner as stated. and due to the ca  29d, DATE SI  3.	SNED (Month, Day, Year)			

32. REASTEAR'S GIGNATURE PROPERTY.

31. DATE FILED (Menth, Day, Year) 93



FOR

THE HORFOLD OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO FRINGEL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be led when 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR		CE	RTIF	ICATE OF	DEAT		REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Li	nsi)					_	2. DATE OF DEATH			3. TIME OF DEATH						
		Gladys G. H	utchins					March 20,		YEAR	8:45 P M						
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (in yrs. lasi	birthday)	IF UNDER 1 YEAR	IF UNDER 24		DATE OF BIRTH	1993	e BIDTUD	LACE (State or Foreign						
	579-44-7995	1   M 2 XXF	95	YRS.	MONTHS DAYS	1	MIN	(Month, Day, Year)		Country)							
	9a. FACILITY NAME (If not institution, g							Dec. 26,1		Ohio							
œ								н		NTY OF DE							
2	Wilson Health	<u> Care Cente</u>	r		Gait	hersb	urg		Mon	tgome	ry						
DIRECTOR	10a. STATE 10b. COL			10c. CIT	Y, TOWN OR LOCA	TION				1	IOd. INSIDE CITY						
E	Maryland	Montgomery				hersb	ura			- 1	LIMITS?						
	10e, STREET AND NUMBER	nonegomer <sub>j</sub>				f. ZIP CODE	, u = 9				☐ YES 2 🔀 NO						
A	201 Russell Aver	0116			["		877		-								
FUNERAL	11. MARITAL STATUS										tates						
	1 Never Married 2 Married		YES 2 N	O	II yes, sp	ecify Cuban,	Maxican,	ORIGIN? (Specify Yan Puerto Rican, etc.)	or No-	14. RACE - Black,	- American Indian, White, etc.						
¥	3 Widowed 4 Divorced	IF YES, GIVE WA	R OR DATES		1 TYES	2 🖄 NO	Specify:		- 1		ite						
	15. DECEDENT'S I	EDUCATION	tte DEC	PEDENTIO	USUAL OCCUPATI	244			<u> </u>		T CE						
COMPLETED	(Specify only highest g	rade completed)	(Gh	ve kind of I	work done during me se retired.)	est of working		16b. KIND OF BUS	INESS/IND	USTRY							
2	Elementary/Secondary (0-12)	College (1-4 or 5+)			Administ	rator		Army Pa	tent	Offi	Ce						
N	17. FATHER'S NAME (First, Middle, Last)									0222	-						
	Thomas G:							(First, Middle, Meiden :	Sumame)								
BE	19a. INFORMANT'S NAME (Type/Print)	i c b c															
2	Ralph G. Hutch:	inc						rte Number, City or Town			60025						
	20e. METHOD OF DISPOSITION	LIIS	7	_				Glenview,									
	1 Buriel 2 X Cremetion 3 F	lemoval from State	cemetery, cren	ND DATE ( natory or o	OF DISPOSITION (Na ther place)	ame of 3/	22/9	3 DATE 200. LOG									
	4 Donation 5 Other (Specify) _ 21. SIGNATURE OF FUNERAL SERVICE		Montg	omer	y Cremat						yland						
	21. SIGNATURE OF FUNERAL SERVICE	T /			22. NAME A	ND ADDRESS	OF FACIL	"Robert A	A. Pu	mphr	ey Funeral						
	*/ Michele &	9. Sutt	M003	348	Home/	Bethe	sda-(	Chevy Chas Bethesda	se, I	nc.,	7557						
	23. PART I. Enter the diseases,	or complications that	caused the dea	ith. Do r	not enter the mo	de of dying	g, auch a	na cardiac or reapir	etory arr	est,	Approximate						
- 13	ahock, or heart fallu	ire. List only one cause	e on each line.								Interval Between Onset and Death						
	disease or condition	Par	lunc	-							Oliset and Daeth						
	resulting in death)		OR AS A CONSEO														
z	50. 50. F=11	- Ce	Coro	200	2nex	(m)	100	Con									
은	Sequentially list conditions, if any, leading to immediate	DUE TO (C	OR AS A CONSEO														
8	cause. Enter UNDERLYING CAUSE (Disease or Injury	c															
區	that initiated events	DUE TO (C	OR AS A CONSEO	UENCE O	F):												
CERTIFICATION	resulting in death) LAST	d															
	PART II Other elevitions and it	Name and the state of															
DICAL	PART II. Other significant condition					g cause giv	ven in Pa	rt I. 24a. WAS AN / PERFOR			VERE AUTOPSY FINDINGS MAILABLE PRIOR TO						
		a 1	rece	le	1	das	20-8	1   YES 2	□XN0	0	OMPLETION OF CAUSE OF DEATH?						
Ш 1	Edlac										☐ YES 2 ☐ NO						
Σ	1 YES 2 NO																
N.			25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)														
CIAN: M					EXAMINER? HOSPITAL: QTHER:												
SICIAN: M		HOSPITAL:	ER/Outpatient 3	□ DOA	QTHER:			Other (Specify)		1   VES 2   THO   1   Inpatiant 2   ER/Outpatiant 3   DOA   4   Nursing Home 5   Rasidence 8   Other (Specify)							
HYSICIAN: M	EXAMINER?  1 VES 2 NO  27. MANNER OF DEATH	HOSPITAL: 1   Inpatiant 2     28a. DATE OF IN	JURY	28b. TIM	OTHER: 4 Nursing Horr E OF 28c, INJ	e 5 🗆 Rask	dence 8 [	Other (Specify)	JURY OCC	CURED							
Y PHYSICIAN: ME	EXAMINER?  1	HOSPITAL: 1 Inpatient 2 I	JURY	28b. TIM	OTHER: 4 Nursing Horr E OF 28c, INJ	e 5 🗆 Rask	dence 8 [		JURY OCC	CURED							
B	EXAMINER?  1 YES 2 TNO  27. MANNER OF DEATH  1 Netural 5 Pending Investigative 3 Suicide 6 Could not	HOSPITAL: 1   Inpetiant 2   1 28e. DATE OF In (Month, Day.	(JURY Year) INJURY — At hon	286. TIM	OTHER: 4 Nursing Horr E OF 28c, INJ	URY AT PRK?	dence 8 [	III. LOCATION (Street In			rte Number,						
B	EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	HOSPITAL: 1   Inpetiant 2   I 288. DATE OF In (Month, Day, on 288. PLACE OF building, et	(JURY Year) INJURY — At hon	286. TIM	OTHER:  4 Nursing Horr E OF 28c, INJ URY WO 1	URY AT PRK?	dence 8 [	Id. DESCRIBE HOW IN			rte Number,						
B	EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigate 2 Accident Investigate 3 Suicide 6 Could not detarmined	HOSPITAL: 1 Inpetiant 2 Inpetiant 2 Inpetiant 2 Inpetiant 2 Inpetiant 2 Inpetiant 2 Inpetial 28e. PLACE OF building, et	NJURY Year) INJURY — At home, (Specify)	28b. TIM INJ	OTHER: 4 Nursing Hom E OF 28c. INJ URY M 1	URY AT HK? VES 2	NO 26	III. LOCATION (Street III. City or Town, State)	nd Number	or Rural Roo	ite Number,						
B	EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigative 2 Accident Investigative 3 Suicide 6 Could not detarmined.  29a. CERTIFIER (Check only)	HOSPITAL:  1 Inpatiant 2 Inpat	IJURY Year)  INJURY — At honic, (Specify)  In y knowledge, dea	28b. TIM INJ ne, larm, s	OTHER:  A Nursing Hon  E OF 28c. IN.  WY  M 1  street, factory, office  at the time, data	URY AT PES 2	NO 26	Bd. DESCRIBE HOW IN  III. LOCATION (Street all  City or Town, State)  The cause(a) and meni	nd Number	or Rural Roo							
COMPLETED BY	EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5 Pending Investigation  3 Suicide 6 Could not detarmined  29a. CERTIFIER (Check only one)  2 MEDICAL EXAM	HOSPITAL:  1 Inpatiant 2 Inpat	IJURY Year)  INJURY — At honic, (Specify)  In y knowledge, dea	28b. TIM INJ ne, larm, s	OTHER:  A Nursing Hon  E OF 28c. IN.  WY  M 1  street, factory, office  at the time, data	uRY AT WES 2 1	NO 2i	BI. LOCATION (Street a. City or Fown, State)  The cause(s) and menie, data and place, and	nd Number her an state	or Rural Rose	and menner as stated.						
BE COMPLETED BY	EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigative 2 Accident Investigative 3 Suicide 6 Could not detarmined.  29a. CERTIFIER (Check only)	HOSPITAL:  1 Inpatiant 2 Inpat	INJURY — At home. (Specify)  In y knowledge, dearmination and/or in	28b. TIM INJ ne, larm, s	OTHER:  A Nursing Hore  E OF 28c. IN.  URY  M 1  street, factory, office  at the time, data  n, in my opinion, d	URY AT PES 2	NO 2i	BI. LOCATION (Street a. City or Fown, State)  The cause(s) and menie, data and place, and	nd Number her an state	or Rural Rose							
BE COMPLETED BY	EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5 Pending Investigates 3 Suicide 6 Could not detarmined  29a. CERTIFIER (Check only one) 2 MEDICAL EXAM  29b. SIGNATURE AND TITLE OF CERTIFIER	HOSPITAL:  1 Inpetiant 2 Inpet	INJURY — At home. (Specify)  y knowledge, deamination and/or in	28b. TIM INJ ne, larm, s	A Nursing Horn  Sec. IN.  WC  M  1  Street, factory, office  at the time, data  n, in my opinion, d	uRY AT WES 2 1	NO 21 and due to d at the tim	mi. LOCATION (Street a) City or Town, State)  The cause(s) and menine, data and place, and R	nd Number ner an state I dun to th 29d. DATE	or Rural Roo	ind menner as stated.						
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PLIAL OH ALIENDING PHYSICIAN; I RE IAM FEQUITES THAT THE CERTINCATE DESTRICTION OF EXPONENT AND A PROPERTY OF THE STATE OF ATTENDING PHYSICIAN.	ERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	in 72 hours after death with the State Dept, or Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: if Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
MILET IN O	FUNERAL DIS	within 72 hou	TTANT: If Ite
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93 09702 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH OF S HERBERT ARLES 0320 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) Dec 29, 5. SFY 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 578 09 9196 79 1 X M 2 | F Dec 1913 WASHINGTON DC 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH WASHINGTON ADVENTIST HOSPITAL DIRECTOR TAKOMA PARK MONTGOMERY RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD. MONTGOMERY TAKOMA PARK 1 X YES 2 | NO FUNERAL 10e STREET AND NUMBER 10f. ZIP CODE 10g CITIZEN OF WHAT COUNTRY? 47 JEFFERSON AVE. 20912 U.S.A 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—If yes, specify, Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 12. WAS DECEDENT, EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried IF YES, GIVE WAR OR DATES Specify: WHITE BY 3 Widowed 4 Divorced WWII COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Glow kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KINO OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) SECURITY GUARD U.S. ART GALLERY 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) WILLIAM H. HERBERT AMY AGNES DAVIS BE 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Floute Number, City or Town, State, Zip Code) 2 AGNES M. HERBERT SAME AS 10 e 20s. METNOD OF DISPOSITION
1/1 Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State cernetery, crematory or other place)
FT LINCOLN CEMETERY 4 Donation 5 Other (Specify) 3/23/93 BRENTWOOD, MD 21. SIGNATURE OF FUNERAL SERVICE LICEN 22. NAME AND ADDRESS OF FACILITY TAKOMA FUNERAL HOME INC 254 CARROLI 4 ST N.W. WASHINGTON, D.C. 20012 23. PART I. Enter the diseases, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line. Interval Betwe IMMEDIATE CAUSE (Finel Onset and Death disease or condition\_ CEREBROVASCULAR ACCIDENT resulting in death) DUE TO (OR AS A CONSEQUENCE OF): HRTERIOSCHEROSIS CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury TYPERTENSION DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST DIABETE PHYSICIAN: MEDICAL

PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24s. WAS AN AUTOPSY THE YES 2 NO

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 YES 2 NO

	HOSPITAL: 1   Inpatient 2   ER/Outpatient 3	DOA 4 Nu	R:	6 ☐ Other (Specify)		
MANNER OF DEATH	26s. DATE OF INJURY	28b. TIME OF	28c. INJURY AT	28d. DESCRIBE NOW INJURY OCCURED		

(Month, Day, Year) 1 Natural 5 Pending investigation м 1 YES 2 NO 2 Accident 3 Sulcide

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Flural Route Number, City or Town, State)

26. PLACE OF DEATN (Check only one)

(Check only	resolution in the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
one)	2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner

a. SIGNATURE AND TITLE OF CERTIFIER	MD	29c, LICENSE NUMBER D11379	29d. DATE SIGNED (Month, Day, Year)

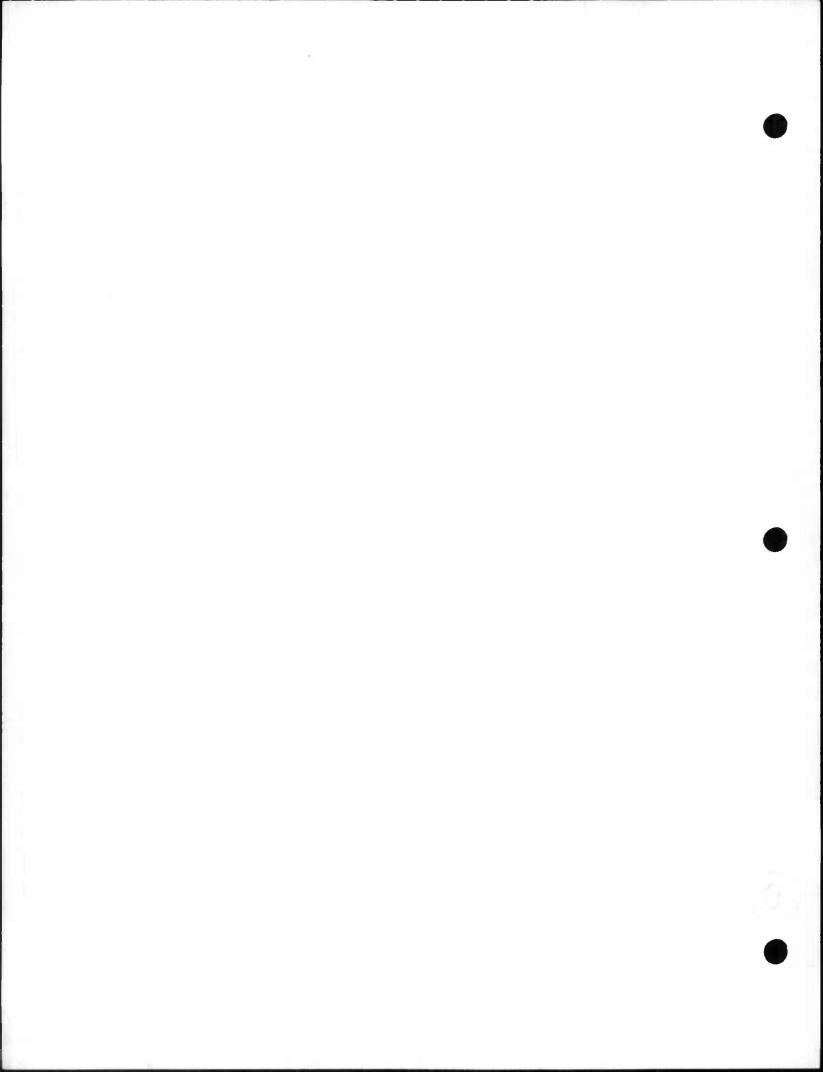
				5.2001
30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)			
MENDUL	4. 0	- P1201	3669	SILTIER SOON
11/2000	MO 9013FLOWER AV	E TO BOX	100	TO TONA PICIT

3. REGISTRAR'S SIGNATURE

25. WAS CASE REFERRED TO MEDICAL

4 Homicide

6 Could not be



Sanjeeb K.

31. DATE FILED (Month, Day, Year)
MAR 2 9 93

Mishra,

MD.

BALTIMORE, MARYLAND 21215-0020	ours after death. Page 6 may be retained by the hospital or attending physician. d in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page or removal.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	THE HINTEL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages the profit of the profit of the profit of the profit of the prior to buriat, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

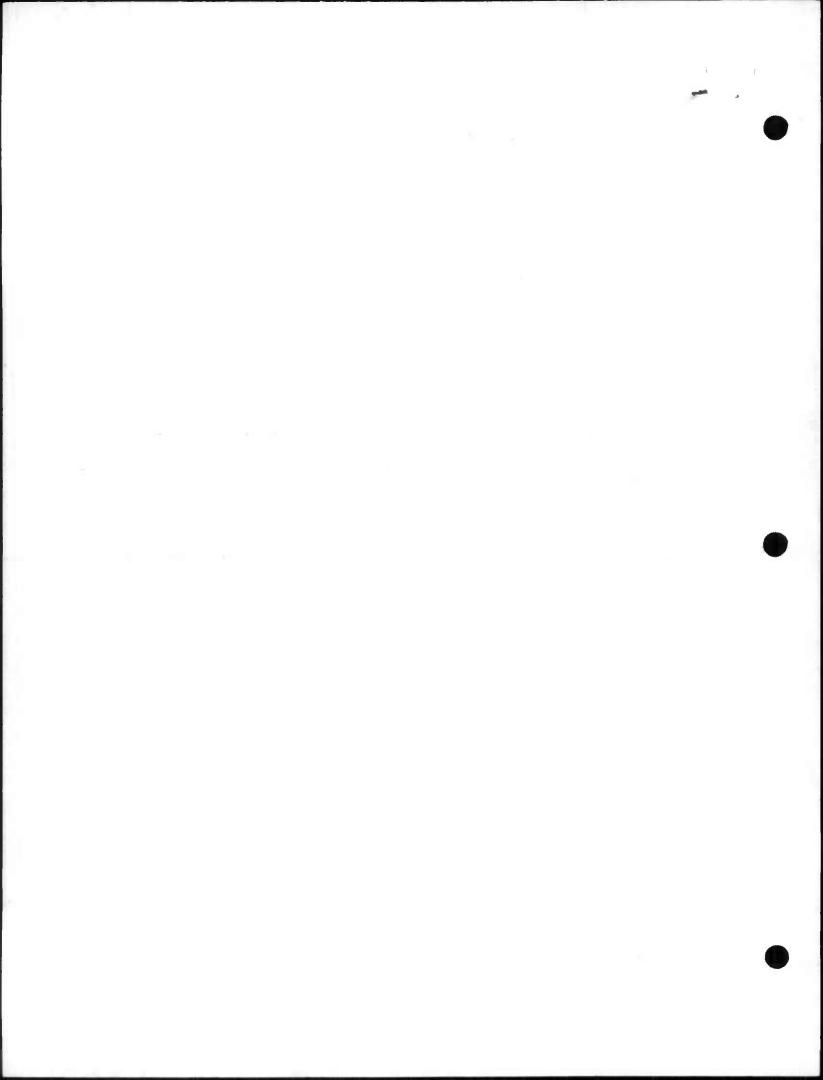
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*	FOR STATE REGISTRAR		STATE OF N	IARYLAND /				EALTH DEAT		MEN'		GIEN 3. NO.					
	1. DECEDENT'S NAME (First, I	Middle, Last)									ATE OF DE	ATH			3. TIME	OF DEAT	н
		lah Wauneta Hanson								0.	3 3	26		93	7:1	0	Ам
	4. SOCIAL SECURITY NUMBE		SEX	6. AGE (In yrs. les	t birthday)	IF UNDER		IF UNDER		7. D/	TE OF BIR	TH.		6. BIRTI	IPLACE (S	State or Fo	reign
7	482-09-625	50	□ M 2 X F	M 2X) F 84 YRS. MONTHS DAYS H				HOURE	MIN.	1	1 - 2 5	1	908	908 Iowa			
	9a. FACILITY NAME (If not inst	titution, give stree	et and number)			9b. CITY	r, TOWN O	R LOCATIO	ON OF DE				9c. COUNTY OF DEATH				
OR	Physicians		al Hospi	tal.		La	Plata	а					Ch	arle	es		
5	RESIDENCE OF DECE	10b. COUNTY				V VOUEL	OR LOCAT										
DIRECTOR			e Geor	ge's		cok									LIM	IDE CITY	
	10e. STREET AND NUMBER			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				10f. ZIP CODE					40.00			S 2	NO
FUNERAL	2400 Rock	500W	Road				101.							IZEN OF V	WHAT COL	JNTRY?	
3	11. MARITAL STATUS			EVER IN U.S. ARI	MED	13	WAS DECI	20607 DECENDENT OF HISPANIC ORIGIN? (Specify Ye				My Man		JSA	- 4	1 1	
	1 Never Married 2 N	farried	FORCES? 1 IF YES, GIVE W	YES 2 XN	0		Il yes, spe	cify Cuber	n, Mexica	n, Puer	rto Rican, e	rtc.)	or No-		E — Amer k, White, i		in,
BY	3 Widowed 4 Divorce	ced		W SALES			1 1 123	277 110	Specify					Spec	hite	9	_
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<b>"</b>	Elementary/Secondary (0-1	12)	College (1-4 or 5+	)				at of working									- 1
COMPLETED	12			Co	ourt	. Cl	erk				_		Gov'	t.			
	17. FATHER'S NAME (First, Mid		1				1				sl, Middle, I	Maiden :	Sumame)				
8	Charles		DIII					Alm									
2	198. INFORMANT'S NAME (Type Rhonda V.		on								umber, City					2000	,
	20g. METHOD OF DISPOSITIO		OII						е.		E.,	_				2000	) 2
	1 Burlai 2 Cremation 4 Donation 5 Other (S	3 🗆 Remove	I from State	20b. PLACEA cemetery, crer Chris	natory or o	her place)	SITION (Nat	ne of		_	1			City or To			
ì	21. SIGNATURE OF FUNERAL		SEE	TCHTIS	st (			D ADDRES			/29	ACC	COKE	eek,	Ma	•	
	"hart	4/2	wha.	M00	0053	T	he H	Hunt	t F	une	eral Wal	Ho	ome,	In	200	504	
	23. PART I Enter the dis-	eases, or con	nplicetions thet	ceused the de	eth. Do r	not enter	the mod	le of dyle	ng, such	h es c	erdlec or	respli	ratory an	reet,		proxima	ite
Ĭ	IMMEDIATE CAUSE (Fina		t enly one caus	e on eech line.	-	DV	· ^	00	00							erval Be	
	disease or condition resulting in death)	<b>•</b>	KPS	KESTRATORY ARREST													
		DUE TO (OF AS A CONSEQUENCE OF):															
No.	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CALISE (Disease or Injury.																
CERTIFICATION	if any, leading to immedicause. Enter UNDERLYIN	ate	O F	DR AS A CONSEC	WENCE OF	TIN	AI	1 AISTILLA									
은	CAUSE (Disease or Injury that initiated events		DUE-TO-	OB AS A CONSEQ	LIENCE OF	- V	V ' F	- 0	1-3	- ( (	1 -						
E	resulting in death) LAST		GAC	TROM	14	20	7/4	A	1	-PA	3MS	P	Ju A	SE	: j		
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<b>A</b>	PART II. Other significent	t conditions of	contributing to	deeth but not re	eulting	in the un	derlying	ceuse g	iven in l	Part i.	24a. W	AS AN	AUTOPSY MED?	24b	WERE AU	TOPSY FIRE	
음	Jan Dui	colli	RU T	ulur	8 6	201	210	48	)		1	YES 2	1			TION OF C	
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PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO EXAMINER?	н	OSPITAL:			OTHER		ACE OF DE	ATH (Che	ck only	one)						
<u>≥</u>	1 YES 2 NO	1		ER/Outpatient 3		4 🗆 Nun	sing Home	_	sidence i	-	ther (Specif	_					
								tk?		28d. [	DEŞCRIBE	HOW IN	JURY OC	CURED			
À	3 Sulpide	vestigation	28a. PLACE OF	INJURY — Al hor	ne farm (			ES 2 _	NO	201 1	OCATION (	Dt-n et in	ad Millionhau		No. 10 Alice		
		ould not be starmined	building, (	etc. (Specify)			, e				city or Town,			or nurar r	iodie ianiiii	oer,	
COMPLETED	29a. CERTIFIER	AING BHAGICIT	N: To the heat of	m kaamb to t	45.44	20	2.1					-	_		-		
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	29b. SIGNATURE AND DRILE D			on andror II	Junganio	,	,on, de				ese and pla	on, and					100.
8	AND THE O		1/1	6				29c. LICE					29d. DAT	E SIGNED	(Month, P	ay, Year)	
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MD. 7C Post Office Road Cenna Center Waldorf, MD.

32. REGISTRANS SIGNATURE

Sulla Devider Road

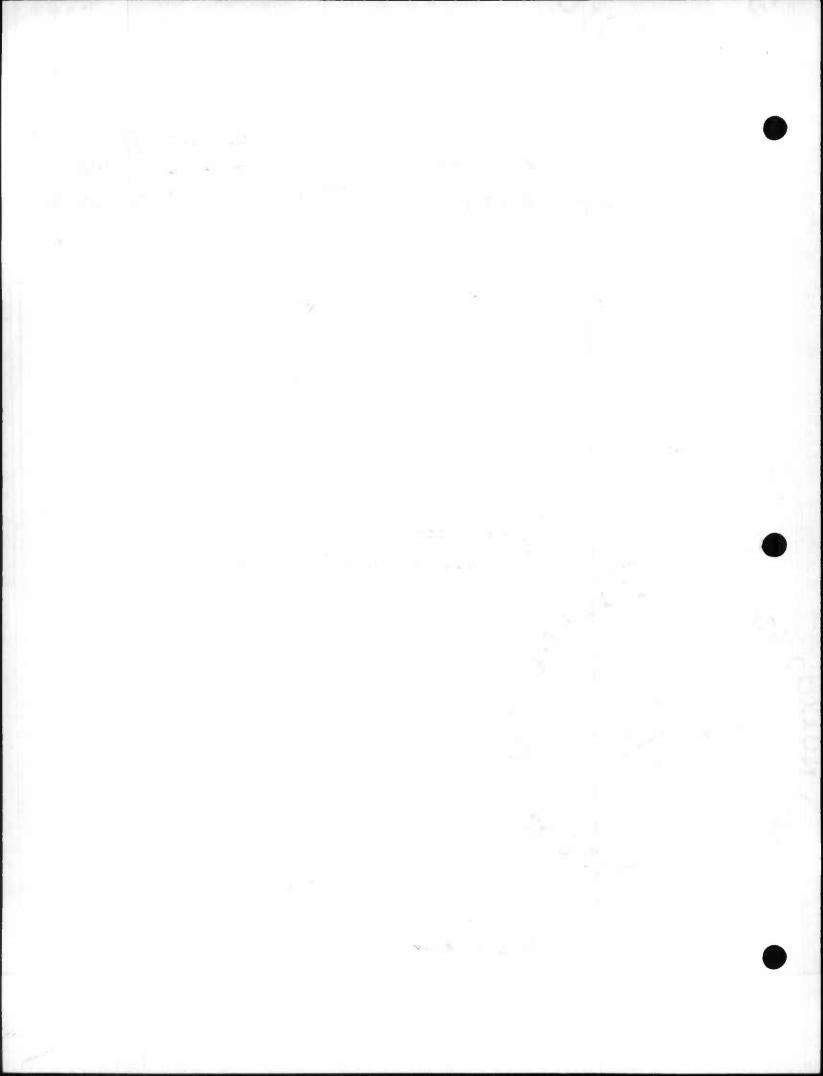
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		1 - STATE OF MARYL REGISTRAR	AND / DEPARTMENT OF CERTIFICATE O		AL HYGIENE REG. NO.					
		1. DECEMBENT TO THE FEB-St, Middle, Last)  Robert Lee		2. DAT MOR	TE OF DEATH	3. TIME OF DEATH  2155 hrs				
ppr	1	215-12-5595 XM20F -	(In yrs. last birthday) IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN. (Mo	TE OF BIRTH WITH PRINT SEAL OF	BIRTHPLACE (State or Foreign Country)				
. 2. 3 should	стоя	9a. FACILITY NAME (If not institution, give street and number), St. Joseph Hospital RESIDENCE OF DECEDENT	Tage 1	OWSOM	sc. COUNT	altimore				
ft. Pages 1.	DIREC	10a. STATE 10b. COUNTY  Maryland Baltimore	10c. CITY, TOWN OR LOC	Parkton		10d. INSIDE CITY LIMITS? 1 YES 2 NO				
n. Insit permit.	FUNERAL	10a. STREET AND NUMBER 2727 Mt. Carmel Road		21120		N OF WHAT COUNTRY?				
5-0020 nding physician. is the burial-transit	B	11. MARITAL STATUS  1 Never Married 2 Merried  3 Widowed 4 Divorced  12. WAS DECEDENT EYER FORCES? 1 YES IF YES, GIVE WAR OR D	2 NO If yes,	ECENDENT OF HISPANIC ORIG specify Cuban, Mexican, Puert ES 2 NO Specify:		I. RACE — American Indian, Black, White, etc. Specify: White				
Z1Z1 al or atte for use a	PLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  12th grade  College (1-4 or 5+)	18a. DECEDENT'S USUAL OCCUPA (Give kind of work done during i Me. Do NOT use retired.)  Real Estate A	most of working	Baltimore ( Governmen	County				
# 8 6 A	BE COMPL	17. FATHER'S NAME (First, Middle, Last) William Raymond Hinton		18. MOTHER'S NAME (First Anna Nell	t, Middle, Maiden Surname)					
ay be retained by page 5 should b	TO B	19a. INFORMANT'S NAME (Type/Print)  B. Lucrecia Hinton	19b. MAILING ADDRESS (Stree 2727 Mt. Car		ember, City or Town, State, Zip Co arkton, Md. 2					
Bust Bust		1 △ Burlal 2 □ Cremation 3 □ Removal from State Cer	b. PLACE AND DATE OF DISPOSITION ( metery, crematory or other place) FOREST Baptist ( 22. NAME	1		, Maryland				
× - 27		R. Lang Posting	934	S. Main Stre		d, Md. 21074				
within 24 hours pletely filled in t cremation, or re-		23. PART I. Enter the diseases, or complications that ceuse shock of heart fellure. List only one ceuse on cilmmediate Cause (Final disease or condition resulting in death)  DUE TO (OR AS.)	d the death. Do not enter the neach line.	-	A Luce	t, Approximate Interval Between Onset and Death				
certificate be executional physician and Hygiene prior to bur other traumatic	ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								
三音音音	AL C	PART II. Other significant conditions contributing to death to	out not resulting in the underlyi	ng cause given in Part I.	24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
y requ	AN: MEDIC					1 _ YES 2 _ NO				
SICIAN: The law certificate has the State Dep	SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 V Inpatient 2 ER/Out	patient 3 DOA 4 Nursing Ho	PLACE OF DEATH (Check only	her (Specify)					
P S S S S S S S S S S S S S S S S S S S	ву Рну	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	INJURY	YES 2 NO	EŞCRIBE HOW INJURY OCCUI	72				
ON ATTENDING DIRECTOR: After hours after death item 28 is ma	LETED	4   Nomicide determined building, stc. (Spe	опу)	CA	OCATION (Street and Number or by or Town, State)					
THE FUNERAL THE FUNERAL TO SHE WITHIN 72 h	COMPL	held only  CERTIFYING PHYSICIAN: To the best of my know  MEDICAL EXAMINER: Do the best of examination  THE AND TYPE OF CERTIFYING		death occured at the time, de						
IN POR	TO BE	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DE	EATH (ITEM 27) (Non-Print)	29c. LICENSE NUMBER	29d. DATE S	24 Q }				
		ATFONSO ( . ZALL) WWW 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGN	10 7620 YO	DICKD TO	n Wood r	W 2/204				
		MAD 2 9 '93	Mary A. Wall							



LONG TOR After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be common to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. ours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 PACING PHYSICIAN; The law requires that the death certificate be executed within 2-**USION OF VITAL RECORDS, P.O. BOX 68760,** 

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1	FOR STATE REGISTRAR	STATE OF MAR	YLAND / DEPAR CERTIF	ITMENT OF HI		REG. NO.	_	
	1. DECEDENT'S NAME (First, Middle, Last)  RAYIV	/OND DAY	/ID HAR	GROVE	2	March 12		3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. last birthday)	IF UNDER 1 YEAR		DATE OF BIRTH (Month, Day, Year)	0. E	BIRTHPLACE (State or Foreign Country)
	577-09-4292	1 M 2 □ F	75 YAS.	MONTHS DAYS	HOURS MIN.	an. 28, 191		eorgia
	9a. FACILITY NAME (If not institution, give st 25670 Yacht Clu			St. Mi	R LOCATION OF DEATI Chaels	н	9c. COUNTY Talbo	
<u>ة</u> [-	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY	,	I soc CIT	Y, TOWN OR LOCATI	ION			10d. INSIDE CITY
œ 1		lbot		t. Micha				1 YES 2 NO
	10a. STREET AND NUMBER	1001			ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
E E	24670 Yacht C	lub Rd.		2	1663		U.S.	Α.
<u> </u>	11. MARITAL STATUS  1 Never Married 2 Married  3 Widowed 4 Divorced	12. WAS DECEDENT EV FORCES? 1 TO IF YES, GIVE WAR O NAVY	YES 2 NO		ENDENT OF HISPANIC celty Cuban, Mexican, F			RACE — American Indian, Black, Whita, atc. Specify: White
	15. DECEDENT'S EDUC	CATION	16a, DECEDENT'S	USUAL OCCUPATIO	N .	16b. KIND OF BUS	SINESS/INDUST	TRY
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)		work done during mos se retired.)	st or working			
ğ L	12		Displa	ıyman		Hargro	ove Dis	splays
5	17. FATHER'S NAME (First, Middle, Lest)					(First, Middle, Maiden	Surname)	
<u> </u>	John Langle	y Hargrove				Parker		
0	19a. INFORMANT'S NAME (Type/Print)				nd Number or Rural Rou			
-	Florrie W. Hargr	ove			lib Rd. S			
	20a. METHOD OF DISPOSITION 1   Surial 2   Cremation 3   Rame 4   Donation 5   Other (Specify)		of cemetary, crematory Olivet Ce	metery	March 1	6, 1993	St. Mic	chaels, Md.216
	21. SIGNATURE OF FUNERAL SERVICE LIC		march	Harris	on E. Leo	onard Fune		
	23. PART <sup>1</sup> 1. Entar the diseasea, or o		used the death, Do					s, Md. 21663 Approximate
	23. PART <sup>5</sup> 1. Entar the diseases, or a shock, or heart failure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)	complications that ca List only one cause of a. PAWOX		CARCII	da of dyling, such a	as cardiac or reap	iratory arrest	Approximate interval Between
CERTIFICATION	shock, or heart failure.  IMMEDIATE CAUSE (Final disease or condition	a. DUE TO (OR DUE TO (OR c.	con each lines	OFF:	da of dyling, such a	as cardiac or reap	iratory arrest	Approximate interval Between Onset and Death
¥ I	shock, or heart failure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	a. DUE TO (OR DUE TO (OR d	AS A CONSEQUENCE OF AS A C	OFF):	oda of dying, such a	as cardiac or reap	I AUTOPSY	Approximate interval Between Onset and Death
¥	shock, or heart failure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	a. DUE TO (OR DUE TO (OR d	AS A CONSEQUENCE OF AS A C	OFF):	oda of dying, such a	as cardiac or reap	I AUTOPSY	Approximate Interval Between Onset and Death Onset and Death 2 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
¥	shock, or heart failure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant condition  25. WAS CASE REFERRED TO MEDICAL	a. DUE TO (OR d. DUE TO dead a contributing to dead a contributing t	AS A CONSEQUENCE OF AS A C	not antar tha modern property of the underlying 26. PL	oda of dying, such a	as cardiac or reap	I AUTOPSY	Approximate Interval Between Onset and Death Onset and Death 2 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
4	shock, or heart failure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other significant condition	a. DUE TO (OR DUE TO (OR d	AS A CONSEQUENCE OF AS A C	DF):  In the underlying	g cause given in Pa	as cardiac or reap	I AUTOPSY	Approximate Interval Between Onset and Death Onset and Death 2 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDICAL	shock, or heart failure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 No  27. MANNER OF DEATH	a. DUE TO (OR d. DUE TO (OR d. HOSPITAL:	AS A CONSEQUENCE O  AS A C	In the underlying  26. PL  OTHER: 4   Nursing Hom  ME OF 28c. INJ.  WE OF 28c. INJ.  WE WO WO WO	g cause given in Pa	art I. 24a. WAS AN PERFOI	AUTOPSY RMED?	Approximate Interval Between Onset and Death Onset and Death 2
BY PHYSICIAN: MEDICAL	shock, or heart failure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO  27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be	a. DUE TO (OR d. DUE TO (AR d. DUE TO (AR d. DUE TO (AR d. DUE TO (AR d. DUE TO (AR d. DUE TO (AR d. D. DUE TO (AR d. D. DUE TO (AR d. D. DUE TO (AR d. D. DUE TO (AR d. D. DUE TO (AR d. D. DUE TO (AR d. D. DATE OF INJ)	AS A CONSEQUENCE O  AS A CONSEQUENCE O  AS A CONSEQUENCE O  AS A CONSEQUENCE O  ATT D	OF):  OF):  In the underlying  26. PL  OTHER: 4   Nursing Hom MC OF   28c. INJ.  UURY   MC   1   1   1   1   1   1   1   1   1	g cause given in Pa	art I. 24a. WAS AN PERFOI 1 YES :	I AUTOPSY RMED?  2 NO  INJURY OCCUR and Number or	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
ED BY PHYSICIAN: MEDICAL	shock, or heart failure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF/DEATH  1 Netural 5 Pending investigation 3 Suicide 8 Could not be determined	a. DUE TO (OR b. DUE TO (OR d.	AS A CONSEQUENCE O  AS A C	OFF:  In the underlying  OTHER: 4   Nursing Hom  ME OF 28c, PL  JURY M 1   N  street, factory, office	g cause given in Pa	as cardiac or reapian as cardiac or reapian	I AUTOPSY RMED? 2 NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
ED BY PHYSICIAN: MEDICAL	shock, or heart failure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF/DEATH  1 Netural 5 Pending investigation 3 Suicide 8 Could not be determined  29a. CERTIFIER (Check only)  1 CERTIFYING PHYS	a. DUE TO (OR b. DUE TO (OR d.	AS A CONSEQUENCE OF AS A C	OF):  In the underlying  OTHER: 4 Nursing Hom  MUOF 28c. RIL  UURY M 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	g cause given in Pa  ACE OF DEATH (Check to 5) Residence 8  Residence 8  Residence 8  ON AT AT AT AT AT AT AT AT AT AT AT AT AT	as cardiac or reapian as cardiac or reapian	I AUTOPSY RMED? 2 NO INJURY OCCUR and Number or in	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
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O BE COMPLETED BY PHYSICIAN: MEDICAL	shock, or heart failure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1   YES 2   NO  27. MANNER OF/DEATH 2   Accident   Pending investigation   Suicide   Could not be determined  29e. CERTIFIER (Check only one)   2   MEDICAL EXAMINER	Examplications that calliate only on a cause of a second of the callian only on a cause of a second of the callian only on a cause of a second of the callian of the callia	AS A CONSEQUENCE O  AS A C	OF):  OF):  In the underlying  26. PL  OTHER: 4   Nursing Hom MC OF 28c. INJ  UURY M 1   Nursing Hom WO 2   Nursing Hom WO 3   Nursing Hom WO 3   Nursing Hom WO 3   Nursing Hom WO 4   Nursing Hom WO 5   Nursing Hom WO 5   Nursing Hom WO 6   Nursing Hom WO 7   Nursing Hom WO 8   Nursing Hom WO 9	g cause given in Pa  ACE OF DEATH (Check to 5 Residence 8  TURN AT PYES 2 NO a 2	as cardiac or reapian as cardiac or reapian	INJURY OCCUR and Number or indicate to the c	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  Rural Route Number,  SUBSECTION OF CAUSE OF DEATH?  1 YES 2 NO

REES & FRANK

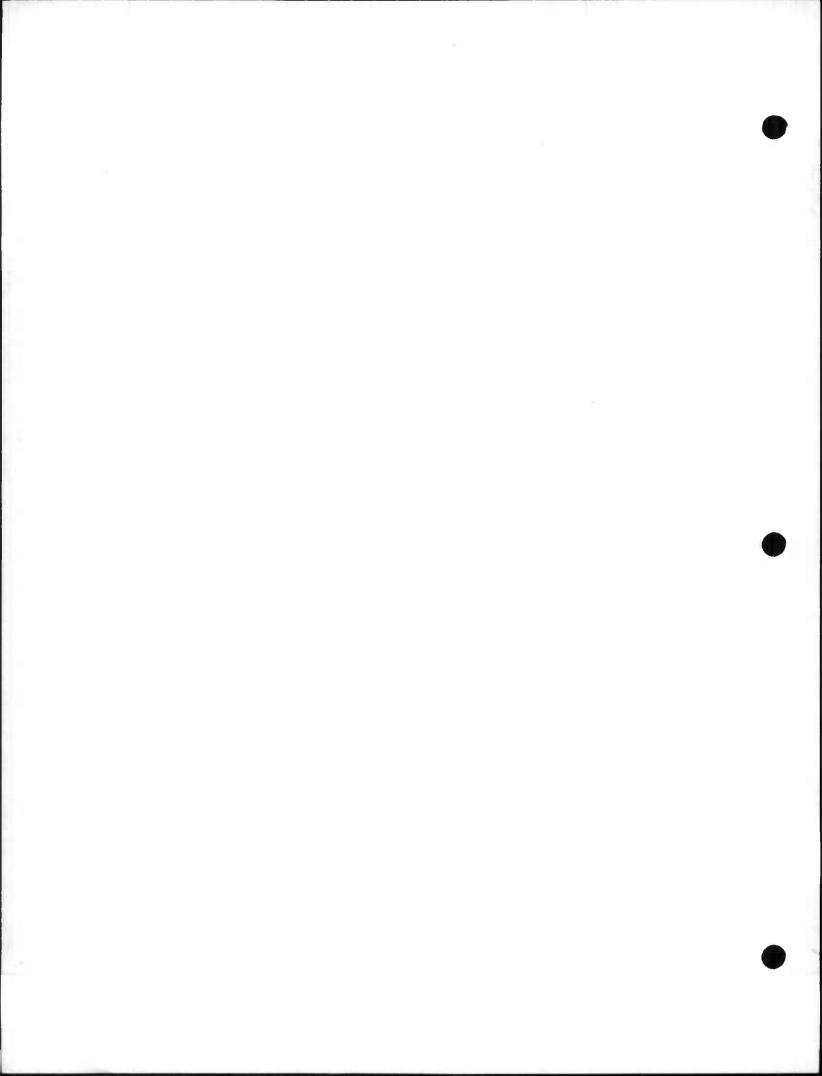
	1 - STATE REGISTRAR			TMENT OF HE		REG. NO.		
- 1	1. DECEDENT'S NAME (First, Middle, Li	nst)	1,,,			2. DATE OF DEATH MONTH DAY	Y	3. TIME OF DEATH
1	Benjamin M. H		1			03 . 16		9:10 P
	4. SOCIAL SECURITY NUMBER	1 1 .	GE (In yrs. last birthday)		IF UNDER 24 HRS.	7. DATE OF BIFTH (Month, Day, Year)	8.	BIRTHPLACE (State or Foreign Country)
	216-44-9387  Se. FACILITY NAME (If not institution, g	1 M 2 - F	80 YRS.			04-07-1912		North Caroli
œ				9b. CITY, TOWN OR	LOCATION OF DEA	ATH 9	c. COUNTY	OF DEATH
5	Holy Cross Hosp	ital		Silver S	pring		Mont	gomery
DIRECTOR	10e. STATE 10b. COL		10c. CIT	, TOWN OR LOCATION	N		_	10d, INSIDE CITY LIMITS?
		ntgomery	Sil	ver Sprin	g			1 YES 2 NO
FUNERAL	100. STREET AND NUMBER			10f. Z	IP CODE	1	0g. CITIZEN	OF WHAT COUNTRY?
W	12902 Flack Str				906		US	
	1 Never Married 2 Married	12. WAS DECEDENT EVE FORCES? 1 Y	ES 2 T NO	If yes, specif	fy Cuben, Mexican	C ORIGIN? (Specify Yes or , Puerto Rican, etc.)	No- 14.	RACE — American Indian, Black, White, etc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OF	A DATES	1 TYES 2	NO Specify:			Specify: White
	15. DECEDENT'S (Specify only highest g			USUAL OCCUPATION ork done during most of	od sundstan	16b. KIND OF BUSIN	ESS/INDUST	
LET	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	e retired.)	a worang			
COMPL		44	Chief P			ent Federa		ernment
_	17. FATHER'S NAME (First, Middle, Last)			1		E (First, Middle, Maiden Sur	mame)	
BE	Benjamin M. Hot	rton	SOL MAN ING	ADDRESS (Dr	Lila B		Na. 4. 10	
2	John T. Horton					oute Number, City or Town, S	, ,	
	20s. METHOD OF DISPOSITION		13417 20b. PLACE AND DATE O	Hathaway	Drive S	Silver Spri	ng M	D 20906 or Town, State
	1 S Buriel 2 Cremation 3 F 4 Donation 5 Other (Specify)		cemetery, crematory or of	her place)		1		
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE	Parklawn	Cemetery 22. NAME AND	ADDRESS OF FAC	HHY I KOCK	Ville	, Maryland
	<b>)</b>	note to				Funeral Ho		2090 Lyon Spring
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR A	S A CONSEQUENCE OF	):		Disar		
MEDICAL	PART II. Other significant condi	tions contributing to deat	h but not resulting i	n the underlying c	ause given in P	Part I. 24a. WAS AN AUT PERFORME  1 YES 2	107	24b. WERE AUTOPSY FIND MAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINERY	HOSPITAL:		26. PLAC	E OF DEATH (Chec	ck only one)		
PHYS	1 Ses 2 NO 27. MANNER OF CEATH	1 Inpetient 2 ER/O		4 Nursing Home				-
ă	Natural 5 Pending	(Month, Day, Yea		URY WORK		28d. DEŞCRIBE HOW INJU	HT OCCUR	EU
ED B	2 Accident Investigation 3 Suicide 8 Could not determined	28e. PLACE OF INJU- building, etc. (S	JRY — At home, ferm, a Specify)			281. LOCATION (Street and City or Town, State)	Number or F	Bural Route Number,
BE COMPLET		NYSICIAN: To the best of my kn		n, in my opinion, deat		ime, data and place, and d	ue to the ca	RUSE(S) and manner as state  GNED (Month, Day, Year)  — ( ) — 9
2	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUSE OF	DEATH (ITEM 27) (Type)	Print	1,715	CONSIN	<u>ر</u>	0 504
- 11	ONK	- Curr Way	_ ~	2-10			4-6	to to
	31. DATE FILED (Month, Day, Year)	32. MEGISTRAB'S SI	GNATURE					

ATTENDING PHISCANI: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

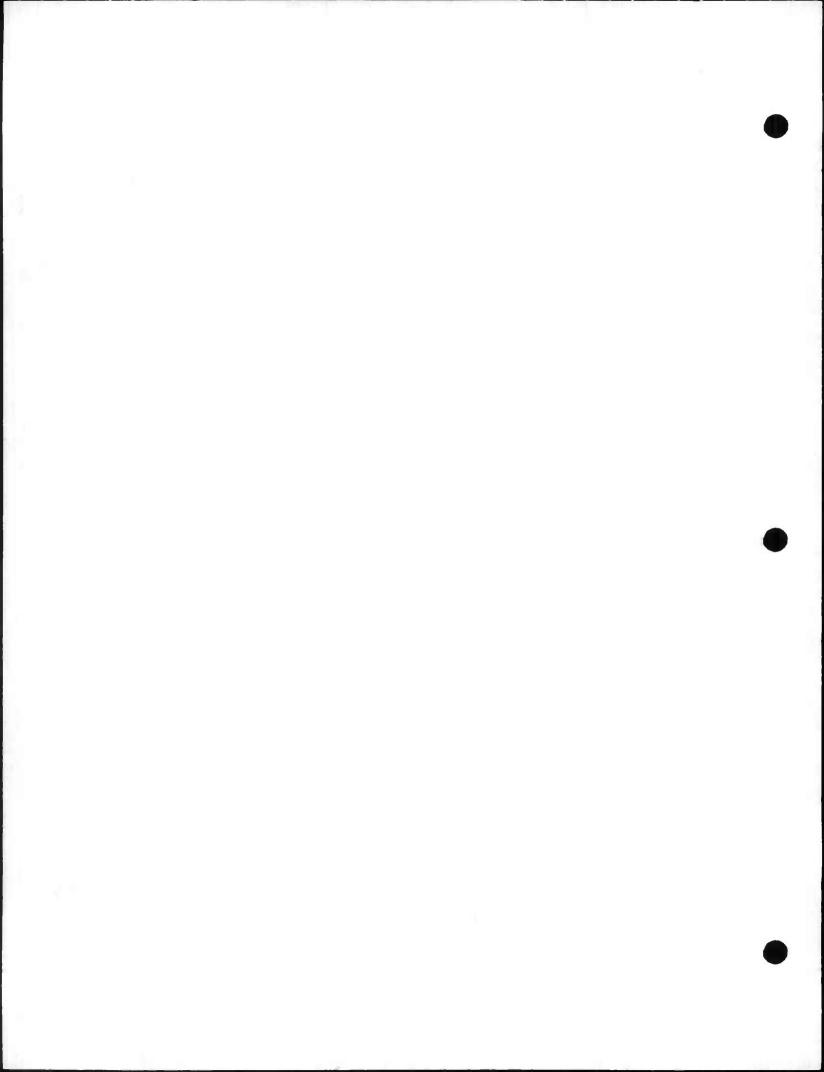
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within or ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital (	INTERIOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for		nt il tem 28 is, marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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0	古	In a hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	윤
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	1 - FOR STATE REGISTRAR		STATE OF I	MARYLAND C				IEALTH DEAT			YGIEN EG. NO.		93	09707
	1. DECEDENT'S NAME (First, YUE HSU		Υι	ue Ying	Hs	u				2. DATE OF MONTH	- O		YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	BER	5. SEX	6. AGE (In yrs. la	t birthday)	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS.	7. DATE OF I	MRTH v. Year)	93	8. BIRT	HPLACE (State or Foreign Iry)
	NONE 9a. FACILITY NAME (If not in	estitution, give s		66	Tho.	9h CITY	TOWN (	OR LOCATI	ON OF DE	Jan 5	, 19		In	dia
DIRECTOR	Montgomer	y Ger		ospita	1		ney	ON EOGAIT	ON OF DE	AIT				omerv
EC	10a. STATE	10b. COUNT	Y		10c. CIT	Y, TOWN C	OR LOCAT	TION						10d. INSIDE CITY
PIG	Virginia	Fair	rfax		Sp	ringt	fiel	d						LIMITS? 1 TYES 2 X NO
FUNERAL	6708 Hackbe	erry Si	treet				16.0	201 E						WHAT COUNTRY?
UNE	11. MARITAL STATUS	JIIy J	12. WAS DECEDEN	IT EVER IN U.S. AF	MED	13.		22150 ENDENT C		IC ORIGIN? (S	pecify Yes		dia	E — American Indian
BY F	1 Never Married 2 0		FORCES? 1	YES 2 X	NO		if yes, sp		n, Mexica	n, Puerto Rica			Blac	E — American Indian, sk, White, etc. sily:
				- Discourse										Chinese
ETE		EDENT'S EDU	completed)	(0	CEDENT'S live kind of Do NOT u	Work done ( se retired.)	CCUPATH during mo	ON ast of worldr	ng	16b. Kill	D OF BUS	SINESS/IN	DUSTRY	
COMPLETED	Unknown	F12)	College (1-4 or 5	1)	usew					0	wn H	ome		
CO	17. FATHER'S NAME (First, M	iddie, Last)						18. MOTI	HER'S NA	ME (First, Midd		Sumame)		
BE	Unavailable		Lapo		5 44 A III 194 C					lable			_apci	nani
욘	Magdalen Z		(Daughte	\	Same			ind Number	or Humil F	loute Number, (	ally or Tow	n, Stete, Zi	p Code)	
	20s. METHOD OF DISPOSITI	ION		20b. PLACE	AND DATE	OF DISPOS	SITION (Na	ame of		OATE	20c. LO	CATION -	City or To	own, State
	4 Donation 5 Donat	(Specify)		- Fairf	ax M	emori	ıaı			3-22	Fa	irfa	x. V	Α
	21. SIGNATURE OF FUNERA	L SERVICE LIC	CENSEE	/		R22.	NAME AI	Fune:	ral S	Servic	es.	P.A.		
	12.A	ler b-	s. Ely		827	93	33 G	ist /	Ave,	Silve	r Sp	ring	, MD	20910
	23/PABT I. Enter the di ahock, or he IMMEDIATE CAUSE (Fir disease or condition resulting in death)	eart fallure.	List only one can	A R	· to	- ~~	the mo	de of dy	Ing, such	n aa cardlac	or respi	ratory ar	rest,	Approximata Interval Between Onset and Death
CERTIFICATION	Sequentially list condition in any, leading to immecause. Enter UNDERLYI CAUSE (Disease or Injuthat Initiated events resulting in death) LAS	diate NG Iry	b. Opue to	(OR AS A CONSE	QUENCE O	Te	Trans	ST	Im	lig	nt	In		1 m/cs
	PART II. Other significa	nt condition	s contributing to	death but not	resulting	In the un	derlyln	g cause (	given in	Part I. 24	. WAS AN		248	. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO
MEDICA	greun	nym	NO 1	V 72.1	-		0			_ 10	YES 2			COMPLETION OF CAUSE OF DEATH?
M	8 row	ngu	XXXXX	umm	ho	3	X	nel	0	-				1 YES 2 NO
AN	25. WAS CASE REFERRED TO	MEDICAL	1111	and	un	as-	20.01	ACE OF D	EATH /Chi	ck only one)			_	
SIC	T   YES 2   MO		HOSPITAL:	EN/Outpatient 3	□ DOA	OTHER 4   Num	4:			B ☐ Other (Sc	ecity)			
PHYSICIAN:	27. MANNER OF DEATH	20000	28e. DATE OF (Month, J)		26b. TM	-	28c. INJ			26d, DESCRI	-	NJURY OC	CURED	
B	2 Accident	Pending Investigation	20 - DI 40E 0	er atv bronze		м		rES 2	NO					
윤	3 Suicide 6 Could not be building, etc. (Spoolfy)  28e. PLACE OF INJUSY: — At home, farm, street, factory, office building, etc. (Spoolfy)  29f. LOCATION (Street and Number or Re. City or Ream, State)							r or Flural	Route Number					
COMPLET		29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
<u> </u>		CAL CVARENT	D . O . M		ırıvestigatio	or, in myjo	pinion, d	eath occur	ed at the	time, date and	place, an	d due to t	he cause(	s) and manner as stated.
				7	1 3	11/1	-	/						
BE	296. SIGNATURE AND TITLE Ronald U	OF CERTIFIER	9	0	UK	+UJ	ew	26 LICE	ENSE NUN		_	29d. DAT	A	(Month, Day, Year)
	29b. SIGNATURE AND TITLE RONALD U: 30. NAME AND ADDRESS OF	OF CERTIFIER SCINS PERSON WH	ki, M.D g completeo cau	Re of OEATH (ITE	М 27) (Туро		ew		PI	5585		> /	Www.	
BE	296. SIGNATURE AND TITLE Ronald U	OF CERTIFIES SCINS PERSON WH	ki, M.D O COMPLETEO CAU	Run	M 27) (Type	e Phi	ilip		PI	5585	ey,	> /	A	nch 93



TO THE POSTAL OF ATENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

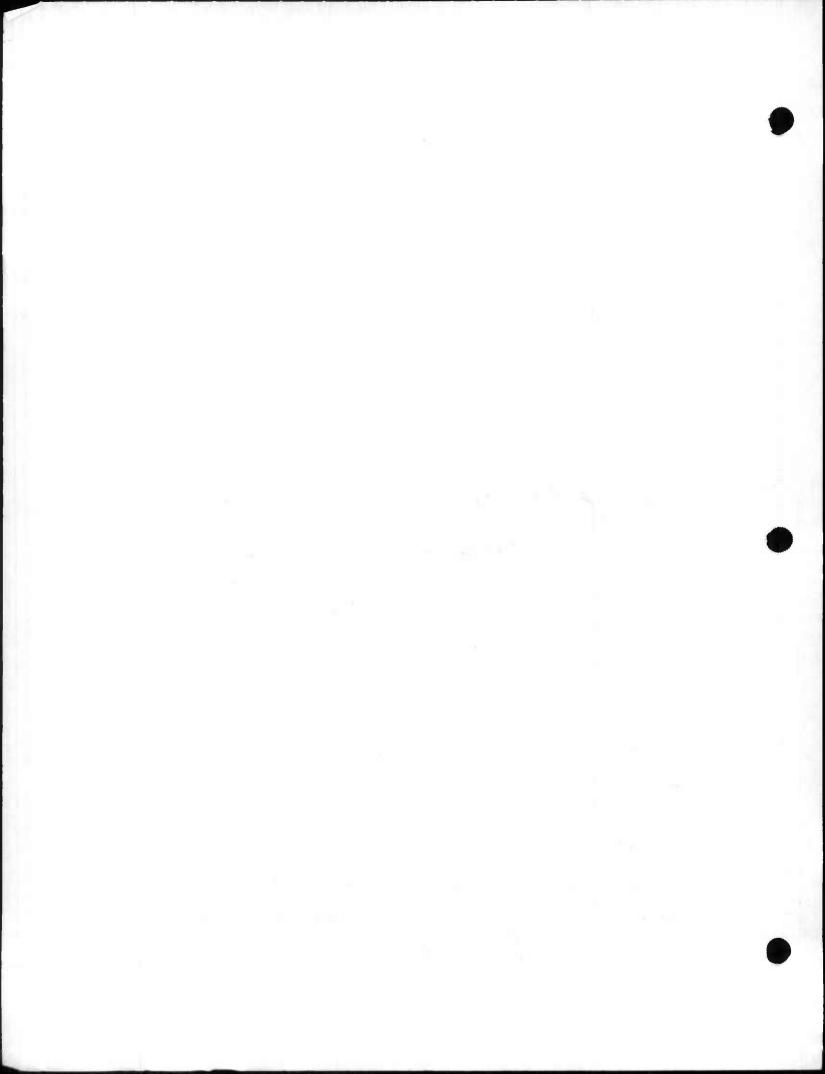
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

_	FOR STATE REGISTRAR
	1. DECEDENT'S NA
	4. SOCIAL SECURIT
	90. FACILITY NAME
בי בייבווער בייורכן	PRES 1
ו נ	10a. STATE
	Maryland
	10e. STREET AND N
	7406
	11. MARITAL STATUS
	1 Never Married 3 Widowed 4
	(Sp Elementary/Seco
	7
	17. FATNER'S NAME
	C. Walt
	19a. INFORMANT'S I
	Gertrude
	20e, METHOD OF DI 1 A Buriel 2 C 4 Donation 5
	21. SIGNATURE OF
	DR.
٦	23, PART I. Enter
ı	ahoc
	IMMEDIATE CAU disease or condi resulting in deat
	Sequentially list if any, leading to cause. Enter UNI CAUSE (Disease that initiated eve
	resulting in deat
	PART II. Other al

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

1. DECEDENT'S NAME (First, Middle, Lest) Gustava G. Haines							2. DATE OF OEATN			DAY YEAR		3. TIME OF OEATN
								03 1	7	43	6 PM	
	213-24-9738		5. SEX	8. AGE (In yrs. last	YRS.	MONTHS DAY		MIN.	7. DATE OF BIRTH	1899	Countr	PLACE (State or Foreign
	9e. FACILITY NAME (If not in			100		9b. CITY, TOW	N OR LOCAT	ION OF DE		Sc. COU	NTY OF O	EATN
DIRECTOR	PRESIDE A	VTIAL	WOODS	NURSIN	4 How	e AI	ELPI	111		Pri	nce G	George's
) E	10a. STATE	10b. COUNT	Υ		10c. CIT	Y, TOWN OR LO	CATION		<del></del>			10d. INSIDE CITY LIMITS?
	Maryland		ntgomery			Takom	a Pari	k				1 X YES 2 NO
FUNERAL	10e. STREET AND NUMBER						10f. ZIP COD			1		VHAT COUNTRY?
N N	7406 Flo	wer A		T EVER BULLO AND	450	1 42 1170	209.					States
BY FU	1 Never Married 2 3 Widowed 4 Divo		FORCES? 1	TEVER IN U.S. ARI YES 2 AN WAR OR DATES	0	It yes,	specify Cubi	an, Mexica	NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)	or No—		E — American Indien, t, White, etc. by; 11te
8	15. DEC	EDENT'S EDU	CATION	16a. DE	CEDENT'S	USUAL OCCUPA	TION		16b. KIND OF BU	SINESS/INI		
COMPLETE	Elementary/Secondary (0	ly highest grede 0-12)	College (1-4 or 5	)) (G/		work done during to retired.) emaker	most of worki	ing	0	wn Ho	ome	
ш	17. FATNER'S NAME (Flost, M C. Walter		ner						ME (First, Middle, Melden et Armel	Sumame)		
TO B	19a. INFORMANT'S NAME (1 Gertrude H.		os						Poute Number, City or Tow Pakoma Par			nd 20912
	20e, METHOD OF DISPOSIT  1	on 3 🗆 Rem	noval from State	20b. PLACE A cemelery, cree Maccedo	natory or or	of Disposition	(Name oB /	22/93	DATE Fre	cation.		wn, State ounty,
	21. SIGNATURE OF FUNERA		CENSEE	Indocac	/11 L CL						Virg	rinia .
	Kah		tana		0198	7557	Beth	esda- onsir	Chevy Cha Ave., Bet	se, l	inc.	20814-3501
NOI.	23. PART I. Enter the g ahock, or h IMMEDIATE CAUSE (Fit disease or condition resulting in death)  Sequentially list condit if any, leading to imme-	eart fellure.	List only one cau	ise on each line.					est			Approximate interval Between Onset and Death
CERTIFICATION	CAUSE (Disease or Injury that Initiated events resulting in death) LAST  DIALETE MODERATION OF THE CONSEQUENCE OF:											
	PART II. Other algnifica	int condition	ne contributing to	death but not re	resulting in the underlying ceuse given in Part 1.			Part 1. 24s. WAS AN PERFOR	PERFORMED?		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
MEDICAL									1 🗆 YES 2	[ <b>¾</b> NO		COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
AN	25. WAS CASE REFERRED TO	O MEDICAL	T									
SICI	EXAMINER?	O MEDICAL	HOSPITAL:	FR/Outpetlant 3		OTHER:	PLACE OF C					
PHYSICIAN	27. MANNER OF BEATH	Pending	28e. DATE OF (Month, D	INJURY	28b. TIM	E OF 28c. URY	NJURY AT WORK?		8 Other (Specify)  28d. DESCRIBE NOW I	NJURY OC	CURED	
D BY	2 Accident 3 Suicide 8	Investigation Could not be	28e. PLACE O building,	F INJURY — At hor etc. (Specify)	ne, farm, s		YES 2	NO	28t. LOCATION (Street of City or Town, State)	and Number	or Rural B	oute Number,
LETE	an ormune 1	determined	ICIAN: To the head of			Támas .			1100 - 1100 - 1100	=		
COMPLETED	one) 2 MEDI	ICAL EXAMINE	ER: On the basis of a						to the cause(e) end mer time, date and place, en			) and manner se stated.
TO BE	296. SIGNATURE AND TITLE	s. Sor	rew The	Atta	ud	ing	0	30		29d. DAT		(Month, Day, Year)
	Gary W.	JONES	MD.	P.O. BO)	r 38	5 La	urel	. M.	1 2072	5		
	31. DATE FILED (Month, Day. MAR 22	<b>'9</b> 3	32. REGISTRA	P'S SIGNATURE	hadeM	۷.						



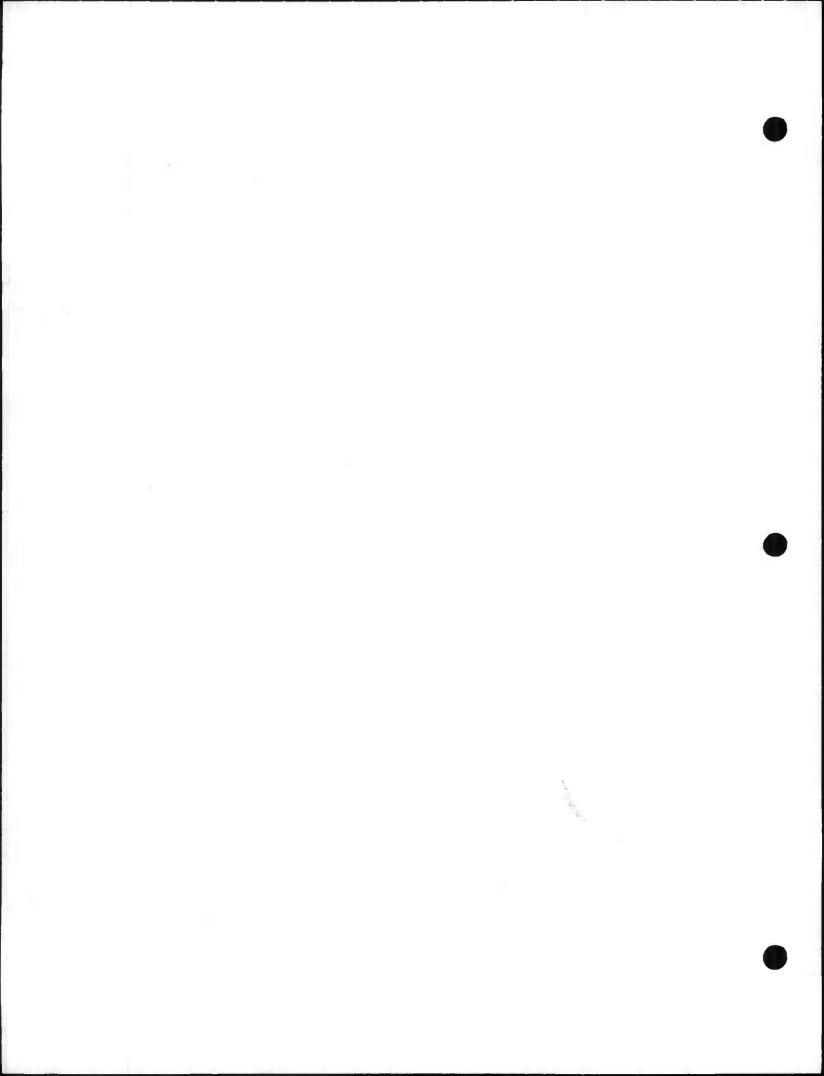
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THAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

RAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 2 hours after death with the State Dent, of Health and Mental Hygiene prior to burial, cremation, or removal.

If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF I	MARYLAND / DEPAR CERTIF	TMENT OF HEALTH AND	MENTAL HYGIENE REG. NO.	30 03103
	1. DECEDENT'S NAME (First, Middle, Lest) MARTH	A MALINDA JO		2. DATE OF DEATH	3. TIME OF DEATH
	MARTHA M	Johnson	IIIVOON	MONTH DAY	93 2:40 P M
	4. SOCIAL SECURITY NUMBER 5. SEX	8. AGE (In yrs. lest birthday)	IF UNDER 1 YEAR   IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRTHPLACE (State or Foreign
	214-03-8049 1□ № 2√2 ೯	7.3 YRS.	MONTHS DAYS HOURS MIN.	(Month, Day, Year) SEPT.11,1919	Country)
	9a. FACILITY NAME (If not institution, give street and number)	, ,	9b. CITY, TOWN OR LOCATION OF D		MARYLAND DUNTY OF DEATH
DIRECTOR	WASHINGTON ADVENTIST HOS	PITAL	TAKOMA PARK	Mo	ONTGOMERY
l iii	10a. STATE 10b. COUNTY	10c. CITY	, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?
	MARYLAND MONTGOMERY		SILVER SPRING		1 YES 2 NO
FUNERAL	10e. STREET AND NUMBER		10f. ZIP CODE	10g. Ct	ITIZEN OF WHAT COUNTRY?
Ü	612 MISSISSIPPI AVENUE		20910		USA
15	11. MARITAL STATUS  12. WAS DECEDEN FORCES?  1 Never Married 2 Married FORCES?	T EVER IN U.S. ARMED	13. WAS DECENDENT OF HISPAI If yes, specify Cuben, Mexico	NIC ORIGIN? (Specify Yes or No-	
8≺	3 💟 Widowed 4 Divorced	YES 2 NO	1 TES 2 TO NO Specif		Specify:
	15. DECEDENT'S EDUCATION				WHITE
H	(Specify only highest grade completed)	(Give kind of w	USUAL OCCUPATION rork done during most of working	16b. KIND OF BUSINESS/II	HOUSTRY
12	Elementary/Secondary (0-12) College (1-4 or 5	"			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	BOOKKEEI		ME (First, Middle, Maiden Surname)	
	CHARLES W. EASTON				<i>)</i>
BE	19a. INFORMANT'S NAME (Type/Print)	10h MAII INC	ADDRESS (Street and Number or Rural	I. ORME	
2	THE TOTAL PROPERTY OF THE PARTY				
	HARRIET L. PHILLIPS (SIST		JPTON DRIVE KEN OF DISPOSITION / Name of	SINGOTN, MARYI	AND 20895  — City or Town, State
	1 🂢 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	cemetery, crematory or of	her place)	1	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	IUNION CEME	22. NAME AND ADDRESS OF FA	B/16 BURTONSV	VILLE MARYLAND
	· 6) -01/-			LLINS FUNERAL	HOME, INC.
_	1 Yay Y		500 UNIVERSIT	Y BI.VD W STI	SPR MD 20001
	23. PART I. Enter the diseases, or complications the shock or heart fellure. List only one car	t caused the death. Do n	ot enter the mode of dying, suc	h as cardiac or respiratory a	arreat, Approximate Interval Between
	IMMEDIATE CAUSE (Finel	60 WESTERN STORY			Onset and Death
	disease or condition	nal F	ailure		3 months
	DUE TO	(OR AS A CONSEQUENCE OF	):		
NO.	Sequentially list conditions,				
ATI	if any, leading to immediate cause. Enter UNDERLYING	(OR AS A CONSEQUENCE OF	):		
임	CAUSE (Disease or Injury C.	(OR AS A CONSEQUENCE OF	)։		
CERTIFICATION	resulting in death) LAST				
	2077 11 011 11 111				
AL M	PART II. Other significant conditions contributing to	deeth but not resulting in	n the underlying cause given in	Part I. 24a. WAS AN AUTOPS' PERFORMED?	Y 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
ğ	Congestive Heart	failure		1 - YES 2 NO	COMPLETION OF CAUSE OF DEATH?
ME	Attra) Fibrillation	<u> </u>		_	1 _ YES 2 _ NO
PHYSICIAN: MEDIC					
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:		26. PLACE OF DEATH (Ch	eck only one)	
YS		ER/Outpatient 3 🗆 DOA	4 Nursing Home 5 Residence	8 Other (Specify)	
	27. MANNER OF DEATH  28e. DATE OF (Month, D. 1 Netural 5 Pending		JRY WORK?	28d. DESCRIBE HOW INJURY O	CCURED
BY	2 Accident Investigation		M 1 YES 2 NO		
COMPLETED	3 Suicide a Could not be 4 Homicide determined	F INJURY — At home, farm, s etc. (Specify)	treet, factory, offica	281. LOCATION (Street and Numb City or Town, State)	er or Rural Route Number,
P	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of	my knowledge, death occurre	d at the time, date and place, and due	to the cause(s) and manner as st	lated.
8	000) 2 MEDICAL EXAMINER; On the basis of e				
BE	29b. SIGNATURE AND TITLE OF CENTIFIER	MD	29c. LICENSE NUI		ATE SIGNED (Month, Day, Year) 3/1 2/9 Z
우	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAU	BE OF DEATH (ITEM 27) (Type.	Print)		.1(2
	MICHARL SCHINDLER	. 1106 SP	ring street s	ilver Spring 1	01602 aw
	31. DATE FILED (Month, Day, Year) MAR 16 '93  32. REGISTRA	R'S SIGNATURE Davidson Mandall	d		



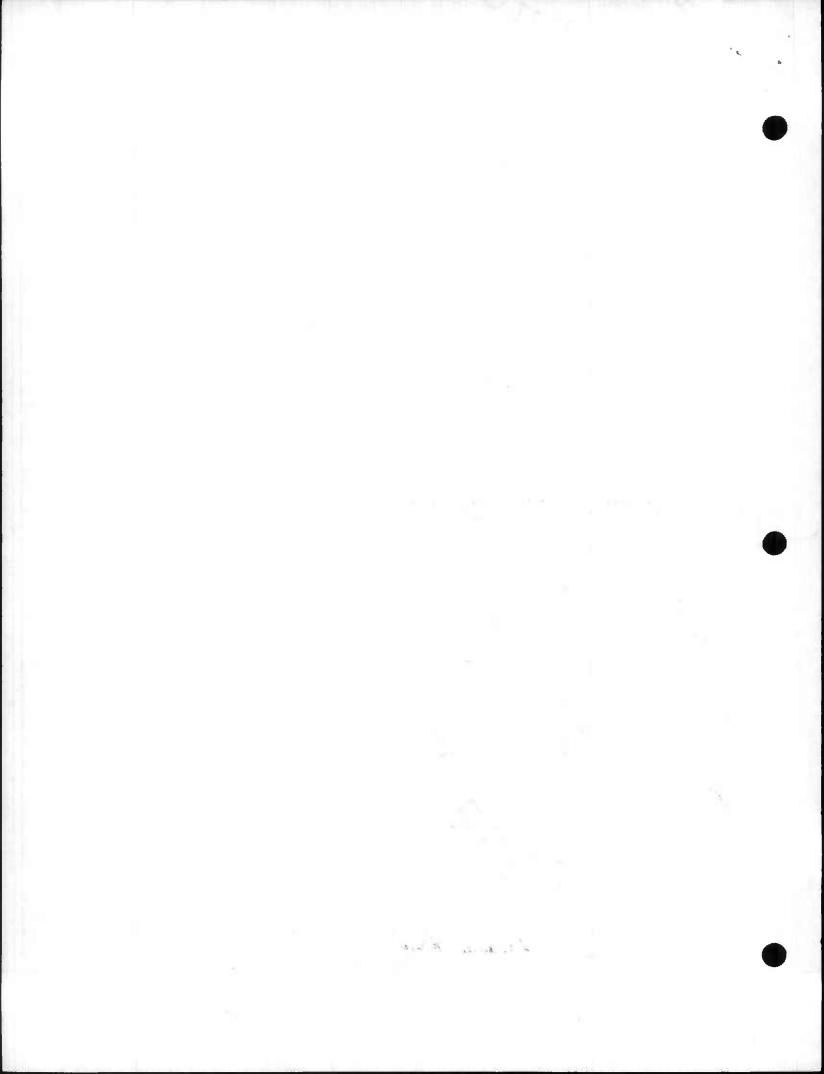
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	And the second s
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TO THE HOSPIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE BUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL		MENT OF H		MENTAL HYGIEN		3 09710
	1. DECEDENT'S NAME (First, Middle, Last)	MARGARET	H. JOC	ELYN				S. 3. TIME OF DEATH
i	2.19-70-6357	1 🗆 M 2 📈 F	(In yrs. last birthday) 35 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Morith, Day, Year) 9/04/19		BIRTHPLACE (State or Foreign Country) MARYLAND
TOR	98. FACILITY NAME (If not institution, give s  COLYSOU COUNT  RESIDENCE OF DECEDENT		P		H WINST		9c. COUNTY	OF DEATH  CARROLL
DIRECTOR	10a. STATE 10b. COUNT MARYLAND	CARROLL	10c. CITY	HAMPS				10d. INSIDE CITY LIMITS? 1 YES 2X NO
FUNERAL	100. STREET AND NUMBER 3504 WOODHOLM				. ZIP CODE	1074	10g. CITIZEN	USA.
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2 12 100	If yes, spe	ENDENT OF HISPAN	NC ORIGIN? (Specify Year, Puerto Rican, etc.)	s or No — 14.	RACE — American Indian, Black, White, atc. Specify: WHITE
LETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed)  College (1-4 or 5+)	16a. DECEDENT'S ( (Give kind of w life. Do NOT use	ork done during mo. retired.)	st of working	16b. KIND OF BU		
COMPLET	17. FATHER'S NAME (First, Middle, Last)				- W 1110	ME (First, Middle, Melder	Surname)	r CLINIC
BE	MA  19e. INFORMANT'S NAME (Type/Print)	TTHEW C. J				UTH I. L.		
욘	NICOLAI S. JO	CELYN						MD. 21074
	20a. METHOD OF DISPOSITION  Separation 2 Cremation 3 Rem  4 Donation 5 Other (Specify)	ioval from State Cen	D. PLACE AND DATE D netery, crematory or oth AKE VIEV	er plece)		3/30 SY	CATION — City	
	21. SIGNATURE OF FUNERAL SERVICE LI		ale	22. NAME AN	D ADDRESS OF FA	ELINE	FUNE	RAL HOME AD, MD.21074
	23. PART i. Enter the diseases, pr shock, pr heart fallure. iMMEDIATE CAUSE (Final disease pr condition resulting in death)	a. Rec	ach line.	6/000		h as cardiac or resp	iratory arrest	, Approximate interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease Dr Injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	areiv	ion,		0	
	PART II. Other algorificant condition	d	out not resulting in	the underlying	cause given in	Part i. 24a. WAS AI	ALITOPSY	24b. WERE AUTOPSY FINDINGS
PHYSICIAN: MEDICAL							RMED?	AMULABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NOT	HOSPITAL:		OTHER:	ACE OF DEATH (Ch			
ЭНХ	27. MANNER OF DEATH	28a. DATE DF INJURY (Month, Day, Year)	28b. TIME	OF 28c, INJ		6 ☐ Other (Specify)  28d. DE\$CRIBE HOW	INJURY OCCUR	ED
B	1. Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY	1347-0	M 1 🗆 1	ES 2 NO	261. LOCATION (Street		
TED	4 Homicide 6 Could not be determined	building, atc. (Spe	city)	reet, rectory, tract		City or Town, State		nurar noute Number,
COMPLETED		ICIAN: To the best of my know ER: On the basic of examination						suse(e) and manner ee stated.
BE C	29b. SIGNATURE AND TITLE OF CERTIFIE	wh Ms			29c. LICENSE NUN		29d. DATE SI	IGNED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WH	-	ATH (ITEM 27) (Type,	Print)	D410	9 1		
	Rajesh CA 31. DATE FILED (Month, Day, Ybar)	La WLA	Cumo	4 Con	nty	gen 1	4051	
	MAR 2 9 'Q3	32 REGISTRAR'S SIGN	Bylath		4			



3. TIME OF DEATH

1 - STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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YEAR OLS Johnson TRAVELIA DONALD 1459 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Morith, Day, Year, 2 2 IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign DAYS 217-28-7070 1 M 2 | F 59 MD after death. Page 6 may be retained by the hospital or attending physician. by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Carroll County Gen. Hospital Westminster Carroll RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Carroll Westminster 1 YES 2 NO FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? Ward Avenue 21157 US 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 1 YES 2

IF YES, GIVE WAR OR DATES

956-1962 Il yes, specify Cuban, Mexican, P.

1 YES 2 NO Specify: 2 NO 1 Never Married 2 Married BY 3 Widowed 4 Divorced white BE COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+) 10 Building Supervisor public schools 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) notified at T. Johnson Florence Cordell 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Thelma Ward Johnson Avenue Westminster, MD 9 20g. METHOD OF DISPOSITION
10 Burlal 2 Cremation 3 Re
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State must Evergreen Memorial Finksburg. MD medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Pritts Funeral Home & Chapel Pritts. Robert K. 412 Washington n by the fremoval. Rd Westminster. MD 23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. Liet only one ceuse on each line. Approximate filled in interval Between 6 IMMEDIATE CAUSE (Final Onset and Death and completely fille burial, cremation, STAPH AUREUS SEPSIS or other traumatic event, the disease or condition\_ resulting in death) DUE TO (OR AS A CONSEQUENCE OF): MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): the attending physician a Mental Hygiene prior to If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury **OUE TO (OR AS A CONSEQUENCE OF):** that initiated events resulting in death) LAST item 23 shows any injury, PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY and RHEUMATOWS ARTHRIPS NIDDM. Signed Health a 1 TYES 2 NO OF DEATH? COPP LPF. 1 TYES 2 NO Deen . BY PHYSICIAN: has be Dept. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF OEATH (Check only one) certificate h EXAMINER? OTHER: Vinpetient 2 ☐ ER/Outpetient 3 ☐ DOA ne 5 🗆 Residence 8 🗆 Other (Specify) 4 🗌 Nurs the item 28 is marked, or 27. MANNER OF DEATH 28c. INJURY AT WORK? DATE OF INJURY 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED this with 1 Natural 5 Pending Investigation N A 1 YES 2 NO After ti 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town. State) 3 Suicide BE COMPLETED 6 Could not be DIRECTOR: hours after 4 Homicide CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

Discretely the cause(b) and manner as stated.

Discretely the cause(c) and manner as stated. 10円 MPORTANT: II within 296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNEO (Month, Day, Year) 29c. LICENSE NUMBER Colorin mo 031660 26 93 3 9 30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) 542 WASHINGTON RD I HOMAK GAINN 21157 WESTMINSTER MO 31. DAT MARP (2019) 01931 37 REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

2. DATE OF DEATH

Pages 1, 2, 3 should

BE COMPLETED BY FUNERAL DIRECTOR

5

TO THE TOTAL STATE THE PROBLEM OF VITAL RECORDS, P.O. BOX 68760.

TO THE TOTAL CONTINUES PHYSICIAN: The law requires that the death certificate be executed within

in the state of th	The Professional American His certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
	TO THE PUNEBAL MIRECTOR: After this	be filed within 72 hours after death wi	IMPORTANT: If Item 28 is marke

BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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FOR STATE REGISTRAR		STATE OF N	IARYL	AND /	DEPAR RTIF	TMEN	NT OF	HEALTH F DEA	AND I	MENTAL HYGIEN REG. NO.	E	9	3 0971
1. DECEDENT'S NAME (First,	Middle, Last)	K	So1	Frie	d Ka	rpe				2. DATE OF DEATH DA	W	YEAR	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER	-	/(4	- p	e_						3 2	9	73	2:30 AM
453-05-0863		1 🔯 M 2 🗌 F	6. AGE		YRS.	MONTHS	DAYI	_	MIN.	7. DATE OF BIRTH (Month, Day, Year) 6-21-1913		Countr	PLACE (State or Foreign ) na, Alabama
Bethesda Re	habili		Nui	rsing	Ctr			NOR LOCATI		ATH		nty of o	EATH
RESIDENCE OF DEC	10b, COUNTY										1101	I C GOIII	
Maryland		tgomery					Cha						10d. INSIDE CITY LIMITS? 1 1 YES 2 NO
10e. STREET AND NUMBER							-	101. ZIP COD	E		10g. CIT	IZEN OF W	/HAT COUNTRY?
3307 Camali	er Dri	ve 2081					5			S.A.			
11. MARITAL STATUS 1 Never Married 2 7 3 Widowed 4 Divo		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO If YES, GIVE WAR OR DATES  13. WAS DECENDENT OF HISPANIC ( If yes, specify Cuben, Maxican, P 1 YES 2 X NO Specify:					n, Puerto Rican, etc.)		14. RACE	- American Indian, White, etc. y: White			
15. DEC (Specify only	EDENT'S EDUC highest grade						TION	·-	166. KIND OF BUS	INESS/IN	DUSTRY		
Elementary/Secondary (0			College (1-4 or 5+) ille. Do NOT use retired.)						Enginee	ring	,		
17. FATHER'S NAME (First, M.	iddle, Last)		16. MOTHER'S NA					ME (First, Middle, Maiden		)			
	D. Ka	rpe	pe Lill					<b>i</b> 11y	e Ernestir	e Fr	ied		
19a. INFORMANT'S NAME (7)	/pe/Print)	19b. MAILING ADDRESS (Street and Num					ot and Number	or Rural F	Route Number, City or Town	n, State, Zij	p Code)		
Eleanor P	incus	Karpe 3307 Camalier Dr., Che					evy Chase,	MD	208	15			
20a, METHOD OF DISPOSITI 1 ☐ Buriel 2 1 Cremation 1 ☐ Donation 8 ☐ Other	ON n 3 - Remo (Specify)	20b. PLACE AND DATE of DISPOSITION (Name of campetery, crematory or other place) Mt. Comfort Crematory 3-23					DATE 20c LO	CATION _	City of To-	wo State			
1. SIGNATURE OF FUNERAL	SERVICE LIC	ENSEE				22	2. NAME	AND ADDRE	SS OF FA	CILITY			V 21
<ul><li>6</li></ul>	A	Rokerto	<u></u>				JOS 513	EPH G	AWLE	R'S SONS, ve., NW Wa	INC.	DC :	20016
23. PART i. Enter the di shock, or he	seeses, or c	omplications that liet only one cau	ceuse se on e	d the dea	th. Do r	ot ente	er the n	node of dy	ng, sucl	h ss cerdiec or reepi	ratory sr	rest,	Approximats interval Between
IMMEDIATE CAUSE (Findisease or condition	ai	Colon Cancer									Onset and Death		
resulting in death)	<b>→</b>	DUE TO (OR AS A CONSEQUENCE OF):									months		
		DOE TO (UTI AS A CONSEQUENCE OF):									i		
Sequentially list conditi If any, leading to immed cause. Enter UNDERLY!	diete NG	DUE TO	DUE TO (OR AS A CONSEQUENCE OF):										
CAUSE (Disease or injuithat initiated events resulting in deeth) LAS		DUE TO	(OR AS A	A CONSEO	UENCE OF	<b>ት</b> :							

conditions contributing to deeth but not resulting in the underlying ceuse given in Pert i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24a. WAS AN AUTOPSY PERFORMED? 1 - YES 2 X NO tastasis 1 - YES 2 - NO Hypertension 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER:

6 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 1 Netural M 1 YES 2 NO 2 Accident
3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 4 Homicide

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated

2 MEDICAL EXAMINER: On the beele of exemination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated.

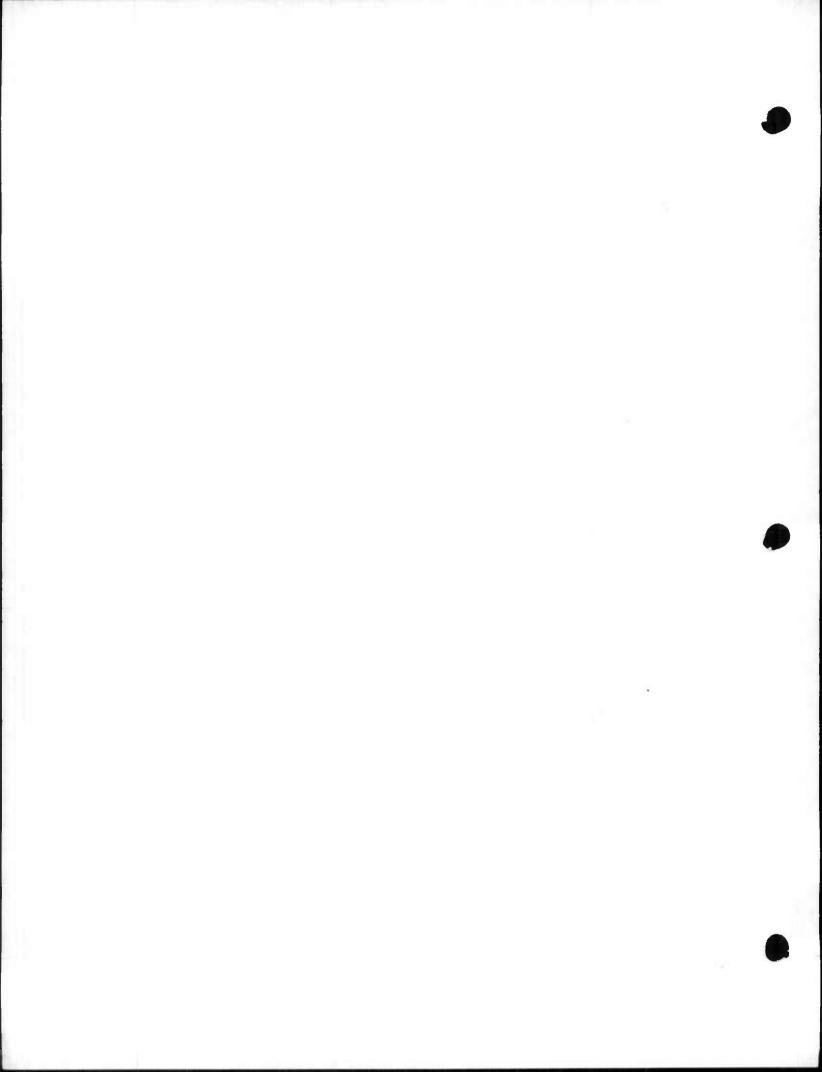
The state of the s	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Y
Jenfell Mar Com	クタンフトチ	> 3/20/53

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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DATE EIL ED /Month	One March				

,03

Julia Davidson

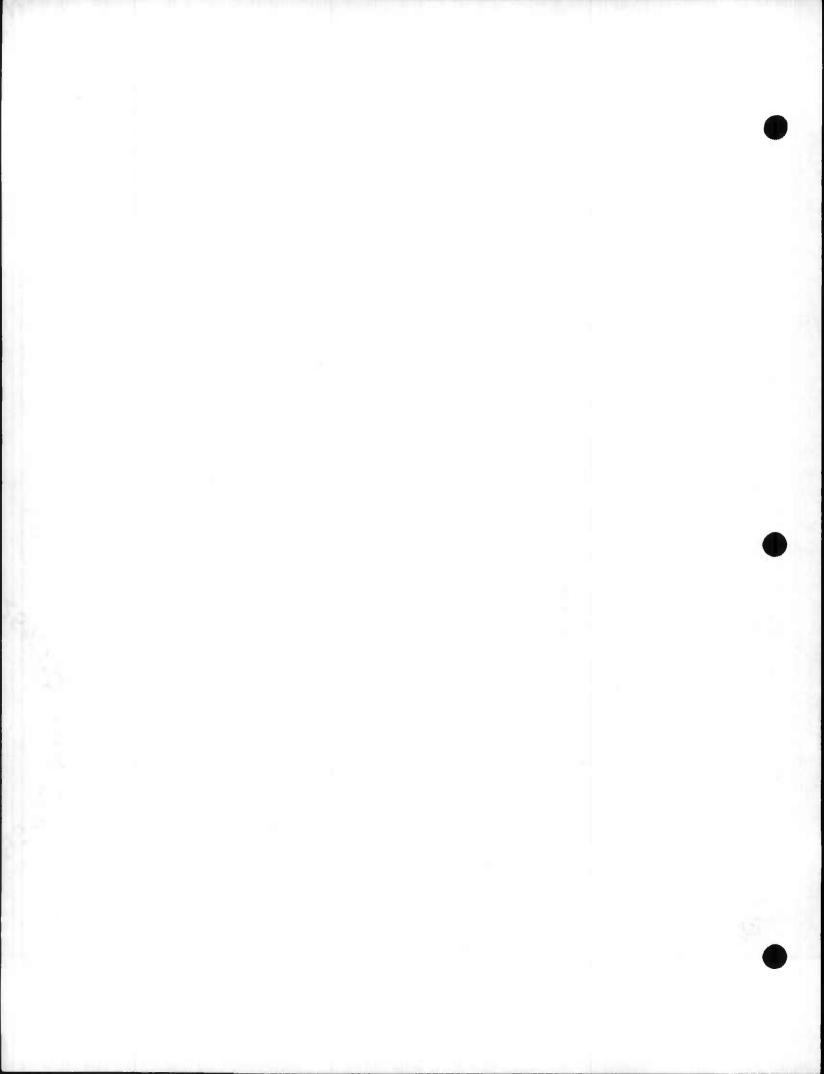


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BALTIMORE	death
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1 - FOR STATE REGISTRAR

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1. DECEDENT'S NAME (First, Middle, Last)  2. DATE OF DEATH MONTH DAY YEAR  3. TIME OF DEATH		1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPAR CERTIF	RTMENT OF H	HEALTH AND I	MENTAL HYGIEN		3 09	713	}
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Tr. MATHER'S NAME (Pist, Modifi, Lat)  1 Homemaker  1 Hower Schwide Romemaker  1 Homemaker  1 Ho		15. DECEDENT'S EOU (Specify only highest grad	JCATION le completed)	(Give kind of	work done during mo		16b. KIND OF BU	SINESS/INDUS			П
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JOHN R. DYJET  The reformatt's NAME (Population 3   Removal from State 2   200 PLACE AND DATE 2   200 PLACE OF DEATH (Number of Plant Rumber o	SOM	17. FATHER'S NAME (First, Middle, Last)		11011101111	aroz.	18. MOTHER'S NA					
Jeanne Kepner Pearson    Separation   Separa	ш			1000000000							
DATE JOB LICATION CONSIDERATION AS Removed from State Congression (Name of Congression As Constitution as Congression as Congr	2		arson							Mn 20	21
22. PART J. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sech line.  NOONED TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, iseding to immediate cause. Enter UNDERLYING CAUSE (Pinel)  AT PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23. PART Security of the cause of t		20a. METHOD OF DISPOSITION	20	b. PLACE AND DATE	OF DISPOSITION (N	ame of					
Rapp Funeral Services, P.A.  933 Gist Ave, Silver Spring, MD 20910  22) PARTY Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final Cause)  Immediate Cause (Final Cause)  DUE TO (OR AS A CONSEQUENCE OP):  DUE TO (OR AS A CONSEQUENCE OP):  AT TOTIO SCIENTIFICATION OF CAUSE OF THE TOTIO SCIENTIFICATION OF CAUSE OF SCIE		4 Donation 5 Other (Specify)		Suburbai				er Spi	ring, M	laryla	n
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AMALABLE PRIOR TO COMPLETED AUSE OF DEATH (ITEM 27) (type, Print)  PERFORMED?  1 YES 2X NO  AMALABLE PRIOR TO COMPLETED AUSE OF DEATH (ITEM 27) (type, Print)  PERFORMED?  1 YES 2X NO  AMALABLE PRIOR TO COMPLETED AUSE OF DEATH (ITEM 27) (type, Print)  AMALABLE PRIOR TO COMPLETED AUSE OF DEATH (ITEM 27) (type, Print)  AMALABLE PRIOR TO COMPLETED AUSE OF DEATH (ITEM 27) (type, Print)  AMALABLE PRIOR TO COMPLETED AUSE OF DEATH (ITEM 27) (type, Print)  AMALABLE PRIOR TO COMPLETED AUSE OF DEATH (ITEM 27) (type, Print)  AMALABLE PRIOR TO COMPLETED AUSE OF DEATH (ITEM 27) (type, Print)  AMALABLE PRIOR TO COMPLETED AUSE OF DEATH (ITEM 27) (type, Print)  AMALABLE PRIOR TO COMPLETED AUSE OF DEATH (ITEM 27) (type, Print)  AMALABLE PRIOR TO 1 YES 2X NO  AMALABLE PRIOR TO 1 YES 2X NO  AMALABLE PRIOR TO 1 YES 2X NO  AMALABLE PRIOR TO 1 YES 2X NO  TO SHELD AUGUST (Type, Print)  AMALABLE PRIOR TO 1 YES 2X NO  TO SHELD AUGUST (Type, Print)  AMALABLE PRIOR TO 1 YES 2X NO  TO SHELD AUGUST (Type, Print)  AMALABLE PRIOR TO 1 YES 2X NO  TO SHELD AUGUST (Type, Print)  AMALABLE PRIOR TO 1 YES 2X NO  TO SHELD AUGUST (Type, Print)  AMALABLE PRIOR TO 1 YES 2X NO  TO SHELD AUGUST (Type, Print)  AMALABLE PRIOR TO 1 YES 2X NO  TO SHELD AUGUST (Type, Print)  AMALABLE PRIOR TO 1 YES 2X NO  TO SHELD AUGUST (Type, Print)  AMALABLE PRIOR TO 1 YES 2X NO  TO SHELD AUGUST (Type, Print)  AMALABLE PRIOR TO 1 YES 2X NO  TO SHELD AUGUST (Type, Print)  AMALABLE PRIOR TO 1 YES 2X NO  TO SHELD AUGUST (Type, Print)  AMALABLE PRIOR TO 1 YES 2X NO  TO SHELD AUGUST (Type, Print)  AMALABLE PRIOR TO 1 YES 2X NO  TO SHELD AUGUST (Type, Print)  AMALABLE PRIOR TO 1 YES 2X NO  TO SHELD AUGUST (Type, Print)  AMALABLE PRIOR TO 1 YES 2X NO  TO SHELD AUGUST (Type, Print)  AMALABLE PRIOR TO 1 YES 2X NO  TO SHELD AUGUST (Type, Print)  AMALABLE PRIOR TO 1 YES 2X NO  TO SHE 1 YES 2X NO  TO SHE 1 YES 2X NO  TO SHE 1 YES 2X NO  TO SHE 1 YES 2X NO  TO SHE 1 YES 2X NO  TO SHE 1 YES 2X NO  TO SHE 1 YES 2X NO  TO SHE 1 YES 2X NO  TO SHE 1 YES 2X NO  TO SHE 1 YES 2X NO  TO SHE 1 Y	o	PART II. Other significant condition	ns contributing to death	but not resulting	in the underlyin	a cause given in	Part I 24a WAS AN	VARITORSY	245 WERE A	ITANS CIMI	uncs
25. WAS CASE REFERRED TO MEDICAL EXAMINER?    25. WAS CASE REFERRED TO MEDICAL EXAMINER?    25. WAS CASE REFERRED TO MEDICAL EXAMINER?    26. PLACE OF DEATH (Check only one)	S	Arterio:	selerotic	Ceret	oro va sa	ular Di	Sect 1 Pers	RMED?	COMPLE	LE PRIOR TO	
25. WAS CASE REFERRED TO MEDICAL  EXAMINER?  1	MEC							<b>X</b> 3			
27. MANNER OF DEATH  1		AS MANO CASE DEFENDED TO MEDICAL									
27. MANNER OF DEATH    Natural   S   Pending Investigation   S   Pending Investigation   S   Suicide   S   Could not be determined   28a. PLACE OF INJURY At home, farm, street, factory, office   281. LOCATION (Street and Number or Bural Route Number, City or Town, State)   28a. PLACE OF INJURY — At home, farm, street, factory, office   281. LOCATION (Street and Number or Bural Route Number, City or Town, State)   28a. CERTIFIER (Check only one)   2 medical examiners on the basis of axamination and/or investigation, in my opinion, death occurred at the lime, date and place, and due to the cause(a) and menner as stated.    Substation   Street and Number or Bural Route Number, City or Town, State)   28a. CERTIFIER (Check only one)   28a. PLACE OF INJURY — At home, farm, street, factory, office   281. LOCATION (Street and Number or Bural Route Number, City or Town, State)   28a. CERTIFIER (Check only one)   28a. PLACE OF INJURY — At home, farm, street, factory, office   28b. LICCATION (Street and Number or Bural Route Number, City or Town, State)   28a. DESCRIBE HOW INJURY OCCURED   28b. DESCRIBE HOW INJURY OCCURED   28d.	5	EXAMINER?		tostient 3 🗆 DOA	OTHER:						_
2 Accident 3 Suicide 4 Homicide 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and menner as stated.  29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 3 Suicide 4 Homicide 29a. CERTIFIER (Check only or fown, State) 29a. CERTIFIER (Check only or fown, State) 29b. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year)			28s. DATE OF INJURY	28b. Til	E OF 28c. IN.	IURY AT		NJURY OCCUP	RED		_
28a. CERTIFIER (Check only one)  29a. CERTIFIER (Check only one)  29a. MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the lime, date and place, and due to the cause(a) and menner as stated.  29c. LICENSE NUMBER  29d. DATE SIGNED (Month, Day, Vear)  29d. DATE SIGNED (Month, Day, Vear)  29d. DATE SIGNED (Month, Day, Vear)  29d. DATE SIGNED (Month, Day, Vear)  29d. DATE SIGNED (Month, Day, Vear)  29d. DATE SIGNED (Month, Day, Vear)  29d. DATE SIGNED (Month, Day, Vear)  29d. DATE SIGNED (Month, Day, Vear)  29d. DATE SIGNED (Month, Day, Vear)  29d. DATE SIGNED (Month, Day, Vear)  29d. DATE SIGNED (Month, Day, Vear)  29d. DATE SIGNED (Month, Day, Vear)  29d. DATE SIGNED (Month, Day, Vear)  29d. DATE SIGNED (Month, Day, Vear)  29d. DATE SIGNED (Month, Day, Vear)  29d. DATE SIGNED (Month, Day, Vear)  29d. DATE SIGNED (Month, Day, Vear)	>				M 1 🗆	YES 2 NO					
29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Dey, Vear) March 23, 1993  Do Name and address of Person who completed cause of Beath (ITEM 27) (Type, Print)  John Gustafson, M.D.  5480 Wisconsin Ave, Chevy Chase, MD 20815	م ا	- October 100 pe	26s. PLACE OF INJUR building, etc. (Spe	IY — At home, farm, ecify)	street, factory, offic		281, LOCATION (Street City or Town, State)	and Number or	Rural Route Nun	nber,	
29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Dey, Vear) March 23, 1993  Do Name and address of Person who completed cause of Beath (ITEM 27) (Type, Print)  John Gustafson, M.D.  5480 Wisconsin Ave, Chevy Chase, MD 20815	MPLE	(Check only K CENTIFYING PHYS									
John Gustafson, M.D. 5480 Wisconsin Ave, Chevy Chase, MD 20815			-	on endor investigation	on, in my opinion, c						.d.
John P. Gustafson, M.D. 5480 Wisconsin Ave, Chevy Chase, MD 20815		John &	· Jula	1	(か)	-					3
5400 MISCONSIN TIVE, CHEVY CHUSC, IN				EATH (ITEM 27) (Type		•	0	Ob a	140	20015	
			THE RESERVE THE PERSON NAMED IN COLUMN 2 I	NATURE	5480 Wi	sconsin	Ave, Chevy	unase	, MD	20815	



BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE CIOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should limboRTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MEN CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last)

TAL HYGIENI REG. NO.	E	20	0311	6-03
RCH 22,	199	3 YEAR	3. TIME OF DEATH	
TE OF BIRTH orith, Day, Year) RCH 4,19	04	Count	PLACE (State or Fore ry) HUANIA	ign
	9c. COL	JNTY OF D	EATH	

LOUIS	SAMUE	L KAT	Z						MARCH	22,	1993	YEAR	1:40 AM M
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. les	t birthdwy)	IF UNDER	R 1 YEAR	IF UNDER	24 HRS.	7. DATE OF (Month, D	BIRTH			PLACE (State or Foreign
032-05-472		tX M 2 ☐ F	89	YRS.					MARCH		004		HUANIA
SUBURBAN H	OSPITA				9b. CITY		OR LOCATI				100	ONTGO	MERY
RESIDENCE OF DEC	10b. COUNTY			I soo CITY	Y TOWN	OR LOCA						7	
MARYLAND		ONTGOMER	Y			CHAS	36,71.0						10d. INSIDE CITY LIMITS?  1X YES 2 NO
10e. STREET AND NUMBER						10	f. ZIP COD	E			10g. CIT	IZEN OF W	HAT COUNTRY?
8100 CO	DNNECT	ICUT AVE						2081				ITED	STATES
1 Never Merried 2 X 3 Wildowed 4 Divo		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	TEVER IN U.S. AR YES 2 WAR OR OATES	MED		If yes, sp	ENDENT (	n, Maxica	NIC ORIGIN? ( in, Puerto Rici y:	Specify Yes an, etc.)	or No—	14. RACE Black Specifi	— American Indian, , Whita, atc. y: WHITE
15. DEC	EDENT'S EDUC	CATION	16a. DE	CEDENT'S	USUAL O	CCUPATIO	DN		16h Ki	ND OF BUS	INESC/INI	MISTRY	MULLE
Elementary/Secondary (0	highest grade	College (1-4 or 5-	+) life.	Do NOT us	e retired.)		ost of working	ng					
17. FATNER'S NAME (First, MI	iddle, Last)	JT		IAII	3110	TAN	10 MOT	MED'S MA	ME (First, Mide			E2 G	OVERNMENT
MORRIS	KATZ						ID	A G	LASER				
19a. INFORMANT'S NAME (7) SHELDON	KATZ								Noute Number,				20904
20a. METNOD OF DISPOSITI		wel from State	20b. PLACE	NDDATEO	F DISPOS	SITION (Na			DATE		CATION —		
4 Donation & Other	(Specify)	Λ	BIRSO						3/24	EVE	RETT	E, M	ASSACHUSETT
21. SIGNATURE OF FUNERAL	SERVICE LICE	ENSEE			DA	NZA		-GOLI	DBERG	MEMOI	RIAL	CHAP	ELS, INC MD. 20852
23. PART & Enter the shock, or he shock, or he shock, or he shock for the shock of	ant tenure. L	ist only one ceu	t caused the de se on each line OCALDIAL (OR AS A CONSEC					ng, sucl	h aa cerdiad	or reepi	ratory arr	reet,	Approximate interval Between Onset and Death
Sequentially list condition if any, leading to immed ceuse. Enter UNDERLYII CAUSE (Disease or injusthat initiated events resulting in death) LAST	diate NG ry c	DUE TO	(OR AS A CONSEC										
PART ii. Other aignificer	nt conditions	contributing to	deeth but not n	sulting Ir	the un	derivino	Ceuse c	iven in	Pert i 24	a. WAS AN	AIIMPSV	245	WERE AUTOPSY FINDINGS
		Congestive	HEALT	FAIL						PERFOR	MED?		AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
25. WAS CASE REFERRED TO EXAMINER?	MEDICAL					26. PL	ACE OF O	EATN (Che	ock only one)				
1 - YES 2 NO		HOSPITAL:	ER/Outpatient 3		OTHER		e 5 🗆 Re	sidenca	8 Other (S)	pecify)			
	Pending nvestigation	28a. DATE OF (Month, D	INJURY sy, Year)	28b. TIME INJU	OF	28c. INJ WO	_		28d. DESCRI		JURY OCC	CURED	
3 Suicide 8 C	Could not be letermined	28s. PLACE O building,	F INJURY — At horate. (Specify)	ne, farm, st	reet, fact	ory, office			28f. LOCATIO City or To	ON (Street a: own, State)	nd Number	or Rural Ac	oute Number,
29a. CERTIFIER (Check only one) 1 CERTI	FYING PHYSIC	IAN: To the best of a	my knowledga, dar tamination and/or is	ith occurred	at the ti	ime, date	and place,	and due	to the cause(	a) and meni f place, and	ner as state	ed. e cause(a)	and menner as stated.
296. SIGNATURE AND TITLE	OF CERTIFIED	net 1					29c. LICE	NSE NUM	IBER				(Month, Day, Year)

30 NAME AND ABORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

BARRY TALESNICK, MD. - 5530 WISCONSIN AVENUE #505 - CHEVY CHASE, MD. 20815

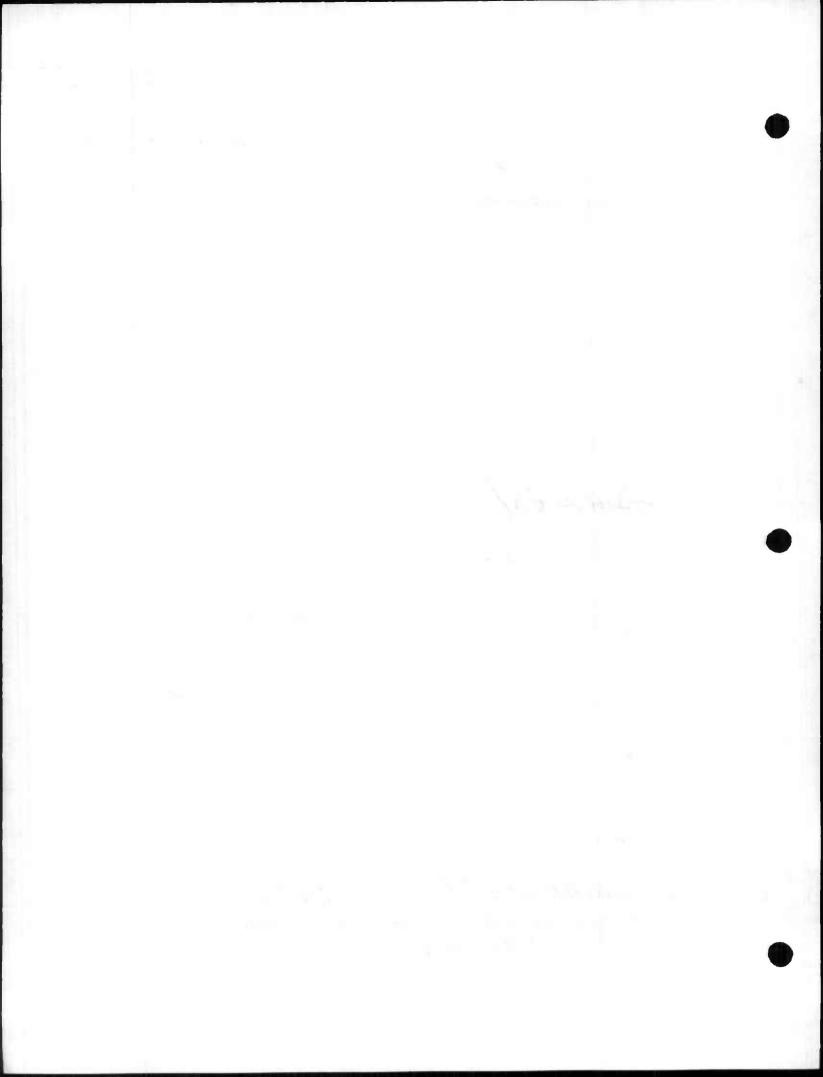
31. DATE FILED (Month, Day, Year)
MAR 25 '93

32. RESISTRAR'S SAMATURE OF

· · · · · · ·

4	
	DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
1	THE HIGH ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hospital or attending physician.
+	TO THE FINERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be made within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examinar must be notified at non-

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.												
	1. DECEDENT'S NAME (First, Middle, Last)	KNOWLES			Know		2. DATE O		3 8	YEAR	TIME OF DEATH P		
COMPLETED BY FUNERAL DIRECTOR	4. SOCIAL SECURITY NUMBER  261-79-3348  9e. FACILITY NAME (If not institution, give	1 - M 2 F 80	YRS.	IF UNDER MONTHS 9b. CITY,	DAYS	HOURS MIN.	Dec :	Day, Year)	12	B. BIRTNPL Country) Texa			
	RESIDENCE OF DECEDENT				lyattsville				Prince George's				
	Maryland Anne Arundel Croft				own or location						Od. INSIDE CITY LIMITS?  YES 2 NO		
	1312 Pear Tree Court				101. ZIP CODE 10g. CITIZEN OF 21114 United								
	11. MARITAL STATUS  1 Never Married 2 Married FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES			11	10 100 00000000000000000000000000000000					- American Indian, White, alc.			
	Elementary/Secondary (0-12) College (1-4 or 5+) Iffe. Do NOT use retired.)					e during most of working !.)							
O.	17. FATHER'S NAME (First, Middle, Last)  4 Homemaker  18. MOTHER'S NAME (First, Middle, Last)						In Home						
BE C	Thomas Richard Sealy				Elizabeth Harper								
5	19a. INFORMANT'S NAME (Type/Print)					Number or Rural I	Route Number	, City or Town	r, State, Zip (	Code)			
	Kenneth Knowles 20a. METHOD OF DISPOSITION		Same										
	1 M Burial 2 Cremation 3 Removal from State condition (Name of condition) ATE 20c. LOCATION — City or Town, State												
	22. NAME AND ADDRESS OF FACILITY												
	Rapp Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD 20910												
	23. PART / Enter the diseases, or shock, or heart failure.  IMMEDIATE CAUSE (Final disease or condition resulting in deeth)	a. ACUTE S	TROKE	not entar t	the mode	of dying, suc	h as cardia	c or reepid	ratory arre	st,	Approximate interval Between Onset and Death		
CERTIFICATION	Sequentially liet conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events  DUE TO (OR AS A CONSEQUENCE OF):  APRIAL PIBRILLATION  DUE TO (OR AS A CONSEQUENCE OF):  C. APPERSOLUBIO CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):												
CER	resulting in death) LAST												
MEDICAL	PART II. Other eignificant conditions contributing to death but not reaulting in the				e underlying ceuae givan in Part i.				24e. WAS AN AUTOPSY PERFORMEO?  1 YES 2 NO		ERE AUTOPSY FINDINGS ARLABLE PRIOR TO OMPLETION OF CAUSE FORATH?  YES 2 NO		
SICIAN:	25. WAS CASE REFERRED TO MEDICAL				20 51 40	E OF BEATH ON							
SIC	26. PLACE OF DEATH (Check only one)  1												
РНҮ	27. MANNER OF DEATN	28a. DATE OF INJURY (Month, Day, Year)	26b. T/M	E OF	28c. INJUR WORK	Y AT		Specify)	JURY OCCU	RED			
BY	Netural 5 Pending (Month, Day, Year) INJURY M					2   NO							
8	3 Suicide 6 Could not be 4 Nomicide 6 Could not be detarmined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  28e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)								e Number,				
COMPLET	29e. CERTIFIER (Check only One)  2  MEDICAL EXAMINER: On the beat of axaminstion and/or investigation, in my opinion, death occurred at the time, data and placa, end due to the cause(a) and menner as stated.												
BE CO	296 SIGNATURE AND TITLE OF CERTIFIED												
5 B	I WALLAND MARLAN	WALL MANEGERALIE INTO					D26331				29d. DATE SIGNEO (Month, Day, Year)  3/23/93		
	NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF OEATN (ITEM 27) (Type, Print) MARTA ANNE SCHWEIDER MD 5401 MACARTHUR BUDNW. WASHIDC 20016												
31. DATE FILED (Month, Day, Year)  AR 25 '93  A Jan Jan Jan Jan Jan Jan Jan Jan Jan Jan													



TO REPORT ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO REPORT After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be to the completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be the completely filled in the medical examiner must be notified at once. TO BE COMPLETED BY FUNERAL DIRECTOR TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG, NO.											
1. DECEDENT'S NAME (First, Middle, Last)	W. K.	SE NIG	7			2. DATE OF DEATH DAY			3. TIME OF DEATH		
4. SOCIAL SECURITY NUMBER  400-03-8593  99. FACILITY NAME (If not institution, gives	1 - M 2 PAE 7	9 YRS.	DAYS	IF UNDER 24 HRS. HOURS MIN.				8. BIRTHPLACE (State or Foreign Country)			
MENEN A	MEREDIA NISG. HOME SILVER SPRING MONT										
MARYLAND MON	TGOMERY		10c. CITY, TOWN OR LOCATION SILVER SPRING								
15510 BAILEYS L			10f. ZIP CODE 209(				0011				
1 Never Married 2 Married 3*_* M/Idowed 4 Divorced	Never Married 2 Married FORCES? 11 YES 2 NO					13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuben, Maxican, Puarto Rican, etc.)  1  YES 2 NO Specify:  14. RACE — American in Black, White, aic.  Specify:  Specify:					
15. DECEDENT'S EDU( (Specify only highest grade Elementary/Secondary (0-12)	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  mentary/Secondary (0-12)  College (1-4 or 5 +)  2  COMPTROLLER					g most of working					
17. FATHER'S NAME (First, Middle, Last) JAMES	FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Meiden Suri SARAH CULV						
19a. INFORMANT'S NAME (Type/Prim)  LARRY D. KOENI				and Number or Rura		ber, City or Town,	State, Zip Co		906		
4 Donation 5 Other (Specify)	Burlei 2 Cremetion 3 Removal from State										
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  FRANKING ADDRESS COLCLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901											
23. PART I. Enter the diseases, or complications that ceused that deeth. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, ehock, or heert failure. Liet only one cause on each line.  IMMEDIATE CAUSE (Finel disease or condition receilting in death)  Put TO (OR AS A CONSEQUENCE OF):											
Sequentially liet conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evanta resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other algoriticent conditions	s contributing to deeth b	ut not resulting in	the underlyle	ng cause given in	Part I.	24a. WAS AN A PERFORM 1 YES 2	ED?		WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?  1 YES 2 NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1   YES 2   NO   No pital:   1   Inpatient 2   ER/Outpetient 3   DOA   4   No pital:   1   No pita											
27. MANNER OF OEATH  1 Natural 5 Pending 2 Accident Investigation	NER OF OEATH Net of Death Net o										
3 Suicide 6 Could not be 4 Nomicide detarmined	Suicide 6 Could not be detarmined 28e. PLACE OF INJURY — At home, tarm, atreet, factory, off building, aic. (Specify)					flice 261. LOCATION (Street and Number or Rural Route Number, City or Yown, State)					
29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER	CAN: To the best of my knowl t: On the beste of exemination	edge, death occurred an and/or investigation, i	nt the time, det	a and place, and du death occured at the	a to the cau	ree(a) and mann and place, and	er as atated. dua to the c	nuse(a)	and manner as stated,		
296. SIGNATURE AND TITLE OF CERTIFIER	man 9			29c. LICENSE NU	3 SH		29d. DATE SI	GNED (	Months Day, Year)		
36, MANGE AND ABBRESS OF PERSON WHO CONFLETED CAUSE OF DEATN (ITEM 27) (Type, Print)  THE WORLD FOR STATE OF DEATN (ITEM 27) (Type, Print)  THE WORLD FOR STATE OF DEATN (ITEM 27) (Type, Print)  THE WORLD FOR STATE OF DEATN (ITEM 27) (Type, Print)											
MAR 26 '93	me Gards	ATURE Randall			,		0				

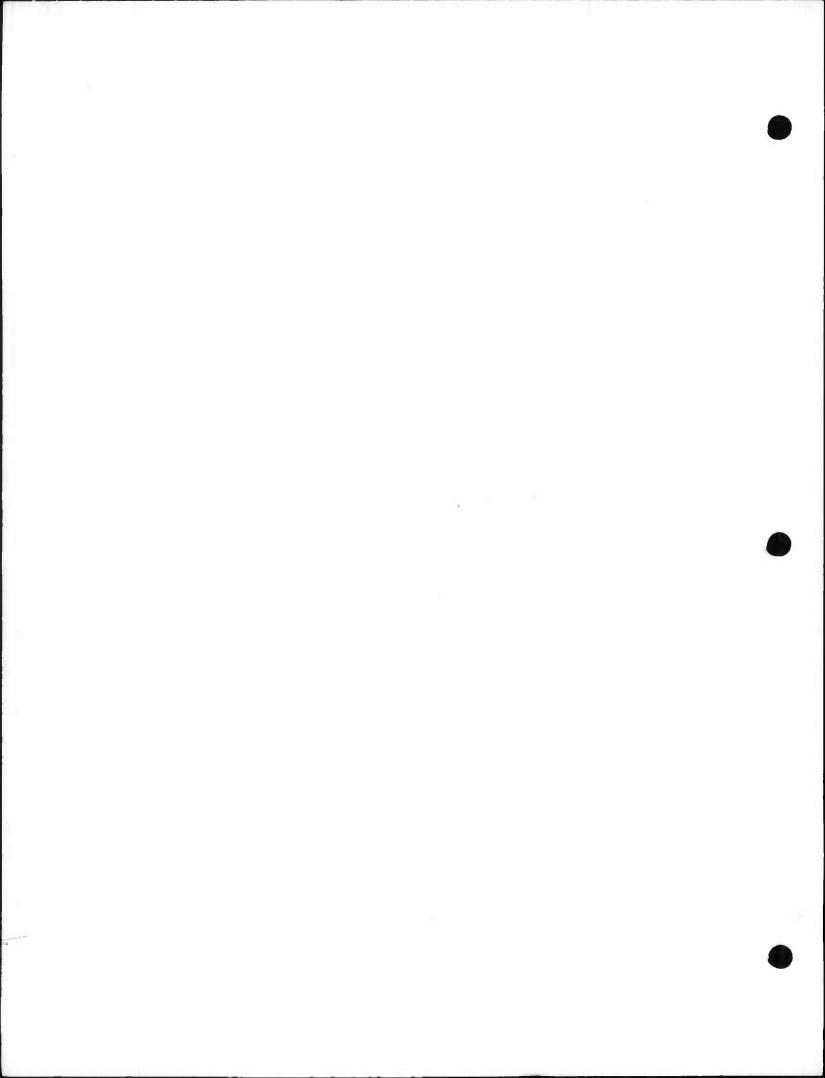
BALTIMORE, MARYLAND 21215-0020

phoods

68760,
BOX
P.O.
RECORDS, I
OF VITAL
DIVISION

the hospital or attending physician.	the	d at once.
hat the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or atten	the attending physician and completely filled in by th Mental Hyglene prior to burial, cremation, or remove	njury, or other traumatic event, the medical examiner must be notified
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death of	portie FUNERAL DIRECTOR: After this certificate has been signed by be filed within 72 hours after death with the State Dept. of Health and	IMPORTANT: If Item 28 is marked, or Item 23 shows any

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM	ENT OF HEALTH AI	ND MENTA	L HYGIENE		03111	
	1. DECEDENT'S NAME (First, Middle, Last	)			2. DATE	OF DEATH		3. TIME OF DEATH	
		ton	Ketchum		Mar		1993	10:00 P .	
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday) IF	RS. 7. DATE	OF BIRTH	8. BIR	THPLACE (State or Foreign intry)		
	199-36-0245 9a. FACILITY NAME (If not institution, give		92 YRS.	THE DAYS HOURS M	June	e 15,19	000	Ohio	
DIRECTOR	Carriage Hill -		90.	Bethesda	OF DEATH		Sc. COUNTY OF	gomery	
IREC	10e. STATE 10b. COUN		10d. INSIDE CITY						
	10e. STREET AND NUMBER	1							
FUNERAL	5215 Cedar Lane	Toy wheat of that							
5	11. MARITAL STATUS	12. WAS DECEDENT EVER	N U.S. ARMED	13. WAS DECENDENT OF H	ISPANIC ORIGIN	? (Specify Yes	or No.— 14, RA	CE — American Indian.	
BY F	1 Never Merried 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 YES	DATES	If yes, specify Cuban, M 1 TES 2X NO S		Rican, etc.)		ock, White, etc. ecity: White	
	15. DECEDENT'S ED (Specify only highest grad	UCATION de completed)	16a, DECEDENT'S USU	AL OCCUPATION fone during most of working	16b.	KIND OF BUSI	NESS/INDUSTRY		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	Iffe. Do NOT use reti	red.)					
OM	17. FATHER'S NAME (First, Middle, Last)	2+	Housewii		S NAME (First, A		Home		
BE C	John Patton				rie Leb				
2	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING ADD	RESS (Street and Number or F	Rural Route Numb	per, City or Town,	State, Zip Code)		
	Janet Whitehous			Box 176, M			22115		
	1 Donetion 8 Other (Specify)	moval from State can	netary, crematory or other p	laca)	DATE		ATION — City or		
	21. SIGNATURE OF FUNERAL SERVICE L	JCENSEE	Homewood Co	22. NAME AND ADDRESS C	F FACILITY		sburgh	PA	
	Micellas	20 /20 Q	don-	Joseph Gawl					
	23. PART I. Enter the disesses, or	complications that caused. List only one cause on a	d the death. Do not e	5130 Wiscon nter the mode of dying,	such as cerd	liec or reepire	itory street,	Approximete	
	IMMEDIATE CAUSE (Final	List only one ceuse on e			,			Interval Between Onset and Death	
	disease or condition resulting in death)	· 194	ocardia	/ Faile	D				
_	_	Arto	CONSEQUENCE OF:	~20					
2	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):	711					
CA	cause. Enter UNDERLYING CAUSE (Disease or injury	c							
CERTIFICATION	that initiated events resulting in death) LAST	OUE TO (OR AS A	A CONSEQUENCE OF):						
	PADT ii Other planificant and disla	O							
CAL	PART II. Other significent condition	ne contributing to death b	out not resulting in th	e underlying ceuse give	n in Part I.	24a, WAS AN AI PERFORM		AMILABLE PRIOR TO	
PHYSICIAN: MEDIC	Vnew	monis				1 TES 2	DWG	OMPLETION OF CAUSE OF DEATH?	
2	72002	ewa io						1 YES 2 NO	
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PLACE OF DEATH	1 (Check only on	9)			
YSI	1 🗆 YES 2 🎮 NO	1 - Inpatient 2 - ER/Outp	outlent 3 DOA 4 ()	HSM: Nursing Home 5 □ Raside	nce 6 🗆 Other	(Specify)			
	27. MANNER OF DEATH  1 D Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?		CRIBE HOW INJ	URY OCCURED		
BY	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY	— At home, farm, street	T TES 2 NO		ATION (Street en	d Number or Rura	I Brude Number	
TE	4 Homicide determined	building, etc. (Spec	cify)		City o	or Town, State)		The running	
COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMIN	BICIAN: To the beat of my know ER: On the beele of examination	ledge, death occurred at	the time, date end place, end	due to the cau	se(a) end manno	er se stated.		
	29b, SIGNATURE AND TITLE OF CERTIFIE		Sec. 1824 Mary Section	29c. LICENSE				O (Mogth, Day, Yeer)	
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٩	30. NAME AND ADDRESS OF PERSON W	10 COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Print)	n. fre, o	01	01	m	/ = ====	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN		1. 17 Pe., C	nay	( her	-,1//	20418	
	MAR 22 '02	Lelia Navida							



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SICIAN: The law requires that the death certificate be executed within 24 hours after death., Page	if the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit, Pages	fal, cremation, or removal.	9
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E	ER.	83	ORTANT If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notifie
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93 09718 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Sarah C. Kieffer MONTH US - 12 -1953 3:40A 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 028-09-1345 0370171904 1 🗌 M 2 🔀 F 89 Massachusetts 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Montgomery General Hospital DIRECTOR Olnev Montgomery RESIDENCE OF DECEDENT 10a STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Montgomery Silver Spring Maryland 1 YES 2 ND FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 19g. CITIZEN DF WHAT COUNTRY? 3563 South Leisure World Blvd. #1C 20906 United States 11, MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify: 1 Never Married 2 Married В 3 Midowed 4 Divorced white COMPLETED 15. DECEOENT'S EDUCATION 16a. OECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 12 Clerk Maritime Administration 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surneme) Stephen J. Curran Delia Kane BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Leo F. Naughton, Jr. 153 East 53rd Street, New York, NY 10022 20s METHOD OF DISPOSITION
1 N Burial 2 Cremation 3 Ramoval from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State Arlington National Cemetery Arlington, Virginia 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22, NAME AND ADDRESS OF FACILITY
Rapp Funeral Services, P. A. leen 933 Gist Avenue, Silver Spring, MD 20910 23. PART I. Enter the disesses, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximate Interval Between **IMMEDIATE CAUSE (Finel** Onset and Death disease or condition\_ Myocardial Infarction resulting in death) DUE TO (DR AS A CONSEQUENCE OF): Bilateral Presmoni PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE DE) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury OUE TO (DR AS A CONSEDUENCE DF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 NO OF DEATH? Hypotensian 1 TYES 2 ND 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 TES 2 ND me 5 - Residence 8 - Other (Specify) 4 - Nursing Ho 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural 2 Accident 1 YES 2 ND В 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 4 Homicide 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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MEDICAL EXAMINER: Do the basis of axaminstion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND HITE OF CERTIFIES 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) BE W

THE CAUSE OF OEATH (ITEM 27) (Type, Print)

32. REGISTRAD'S SIGNATURE
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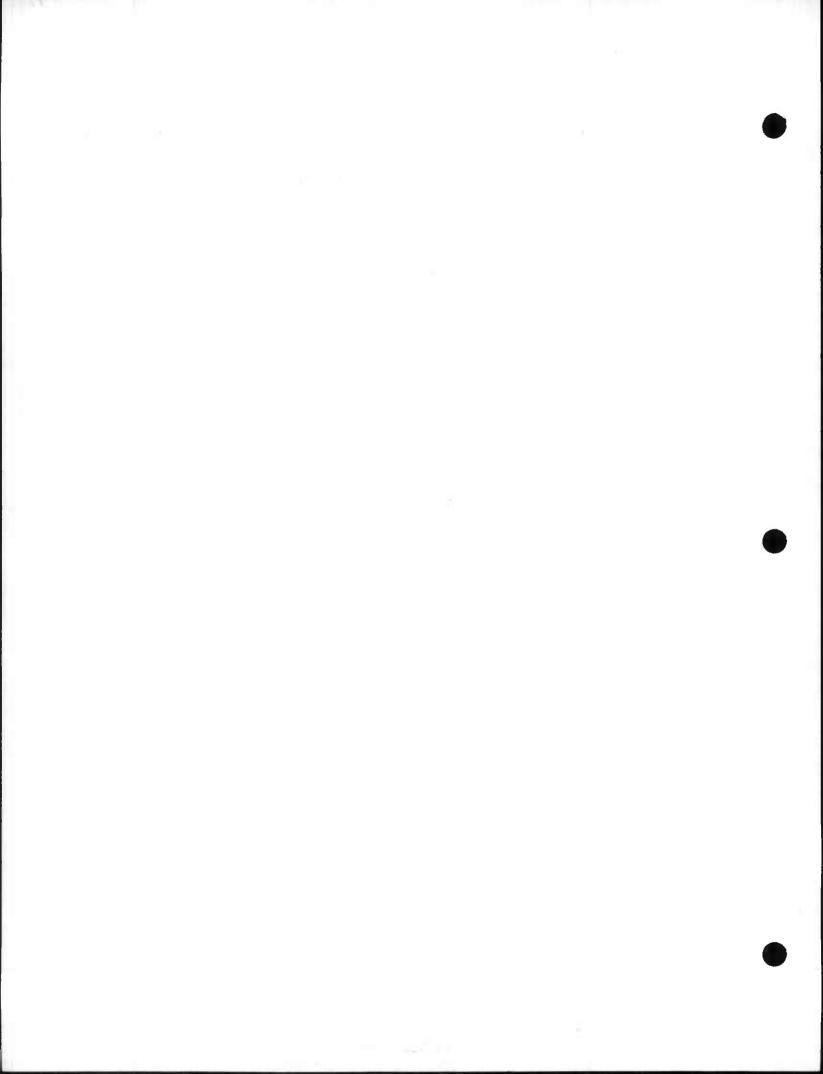
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31. DATE FILEO (Month, Day, Year) 22



e burial-transit permit. Pages 1, 2, 3 should

TO THE HINTER OING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending	TO THE FULL FALL CONTINUES TO After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the	led within though mit the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE H	TO THE F	be filed w	IMPORT

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH DAY YEAR DELLA MAE KUSTER 3-14-5:40 A 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIFITHPLACE (State or Foreign 1 - M 2XXF 217-20-7834 DEC. 9, 1923 MARYLAND 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR SUBURBAN HOSPITAL BETHESDA MONTGOMERY RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND MONTGOMERY ROCKVILLE TY YES 2 | NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WNAT COUNTRY? 13115 MIDWAY AVENUE 20851 UNITED STATES 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 22 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No If yes, specify Cuban, Maxican, Puerto Rican, atc.)

1 YES 24 NO Specify: 14. RACE --- American Indian, Black, White, atc. 1 Never Married 2 K KMarried IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced WHITE COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) ISAAC VAN SIRK ADDIE AGNES BUTLER BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 RICHARD L. KUSTER 13115 MIDWAY AVENUE, ROCKVILLE, MARYLAND 20851 20a. METHOD OF DISPOSITION
1 N Burlel 2 Cremation 3 Removel from State 20b. PLACE AND DATE OF DISPOSITION (Name of 122/93 20c. LOCATION — City or Town, State DATE GATE OF HEAVEN CEMETERY 4 Donation 5 Other (Specify) SILVER SPRING, MD 21. SIGNATURE OF FUNERAL SERVICE LICES 22. NAME AND ADDRESS OF FACILITY ROBERT A. PUMPHREY FUNERAL HOME/ROCKVILLE, INC. 300 WEST MONTGOMERY K0800M AVENUE, ROCKVILLE, MARYLAND -2805 23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such se cerdiec or reepiratory arrest, **Approximate** shock, or heart failure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Fine) **Onset and Death** diseese or condition\_ Colod Cruce METASTATIC resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Rentm DENTE FAILU dar PHYSICIAN: MEDICAL CERTIFICATION Sequentielly list conditione, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate Hyper Kalen A ceuse. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events NUCTIONA de resulting in deeth) LAST BAHA PART ii. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 TES 2 NO OF DEATH? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one. HOSPITAL: OTHER: 1 TYES 2 NO 1 (Tipatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Return 5 Pending ВҰ 1 YES 2 NO 2 Accident Investigation 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 4 Homicide 29a. CERTIFIER 1 SERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF **GERTIFIE** 29d. DATE \$IGNED, (Month, Day, Year) BE 29c. LICENSE NUMBER 3 92 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) OCCIA 1308PHY 31. DATE FILED (Month, 32. HE DESTRICT SIGNATURE GUILDE VALUE VAL **\*9**3

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<b>MARYLAND 21215-0020</b>	attending
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

permit. Pages 1, 2, 3 should	
spital or attending physician. hed for use as the burlal-transit	
lage 6 may be retained by the hy director, page 5 should be detace er must be notified at once	
YSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  S certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  In the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  In the State Dept. of Health and Mental Hygiene prior to burial, the medical examiner must be notified at once.	
SICIAN: The law requires that the death certificate be executed within 24 hours after of certificate has been signed by the attending physician and completely filled in by the 1h the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. d, or Item 23 shows any Injury, or other traumatic event, the medical es	
PHYSICIAN: The law requires th this certificate has been signed with the State Dept. of Health rked, or Item 23 shows an	
THE HISPITAL OR ATTENDING THE FLAEPAL DIRECTOR: After WITHIN 72 hours after death ONTANT: If item 28 is ma	
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30. NAME AND ADDRESS OF REPORTS O

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	FOR 1 - STATE	STATE OF N	MARYLAND /	DEPAR	TMENT OF	HEALT	H AND	MENTAL HYGIEN	iE (	J 3	00720		
	REGISTRAR  1. DECEDENT'S NAME (First, Middle, Lest)		CI	RTIF	ICATE C	F DE	ATH	REG. NO			03120		
	Frances Ciam	na Lawson	1					2. DATE OF DEATH	w3/19	190	3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (in yrs. las	a bilatholmel	IF UNDER 1 YEA	- 1 15 (1945	-7.01100		91		3:50 pm		
	092-12-7839	1 M 2 X F	7.4	YRS.	MONTHS DAY		ER 24 HRS.	7. DATE OF BIRTH (Magth, Day, Year) 2/16/19	1	Country)			
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<u>m</u>	the state of the s	2621 Speciments of Court											
[유	12621 Springloch Court Silver Spring Montgome								ry				
DIRECTOR	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION							10d. INSIDE CITY					
									1 YES 2 □ NO				
ĭ≱∣	10e. STREET AND NUMBER					10f. ZIP CO	DE		10g. CIT	ZEN OF WH	IAT COUNTRY?		
FUNERAL	12621 Springloc					20	904		Uni	ted S	tates		
5	11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEDEN' FORCES? 1	T EVER IN U.S. AR	MED	13. WAS I	BOOCITY CU	OF HISPA	NIC ORIGIN? (Specify Year, Puerto Rican, etc.)	s or No—	14. RACE - Black.	American Indian, White, atc.		
ΒY	3 Widowed 4 Divorced	IF YES, GIVE W				ES 2 X N				Specify:			
	15, DECEDENT'S EDU	CATION	16a DE	CEDENT'S	USUAL OCCUP	TION		16b, KIND OF BU	011/200/01/		White		
	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5 +	(G	ive kind of a	vork done durina	most of wor	king	166. KIND OF BU	SINESS/IN	JUSTRY			
립	12	0	·	me Ca	are Pro	wide	r	Person	101 C	220			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		110	ine of	are ire			AME (First, Middle, Maider		are			
BE C	Carlo Marinac					Mai	ry Kl	ecek					
0 8	19a. INFORMANT'S NAME (Type/Print)		191	. MAJLING	ADDRESS (Stre			Route Number, City or Tov	vn. State, Zip	Code)			
=	Arthur W. Ciampa	a	1	2621	Spring	loch	Cour	t, Silver	Spri	ng. M	D_20904		
	20a. METHOD OF DISPOSITION 1	ovel from State	20b. PLACE	ANDDATE	OF DISPOSITION					City or Town			
	4 Donation 5 Other (Specify)		cemetery, cre-	nham nham	Cemete				ison	, PA			
	21. SIGNATURE OF FUNERAL SERVICE LIC	1	12			AND A OOF		CILITY					
	1 Mullen	ace s	tece					Funeral H			G 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
	23. PART I. Enter the diseases, or o	complications that	caused the de	eth. Do r	ot enter the	mode of d	y nam	th as cerdiec or read	iretory an	LIVer	Spring, MD		
	shock, or heart failure.  IMMEDIATE CAUSE (Finel	List only one cau	se on each line							,	interval Between Onset and Death		
	disease or condition	(1)2	RCin	in	2 06	1	11-				d to 0		
	resulting in death)	DUE TO	RCI Y	DUENCE OF	7):		ar	ig			1912		
z		b.									1		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	OR AS A CONSEC	DUENCE OF	f):								
5	cause. Enter UNDERLYING CAUSE (Disease or Injury	c											
E	that initiated events resulting in death) LAST	OUE TO	OR AS A CONSEC	DUENCE OF	7):								
5		d		_									
· . I	PART II. Other aignificant condition	a contributing to	deeth but not n	esulting i	n the underly	ing cause	given in			24b. W	VERE AUTOPSY FINDINGS		
MEDICAL								PERFO		0	WAILABLE PRIOR TO COMPLETION OF CAUSE		
									NO		OF DEATH?		
=								_			YES 2 NO		
Ž.	25. WAS CASE REFERRED TO MEDICAL				26	PLACE OF	DEATN (Ch	eck only one)					
Sic	1 YES 2 NO	HOSPITAL: 1   Inpetient 2	ER/Outpatlant 3	□ DOA	OTHER:	ome 5	Raaldence	6 Other (Specify)					
PHYSICIAN:	27. MANNER OF DEATN	28a. DATE OF (Month, Da		28b. TIM		INJURY AT		28d. DESCRIBE NOW	NJURY OC	CURED			
BY	1 Natural 5 Pending Investigation	(MONIT, De	y, rour)	ING		WORK?	□ NO						
	3 Suicide 8 Could not be	28s. PLACE Of building,	INJURY — At hor	me, farm, s	treet, factory, o	Hice		281, LOCATION (Street City or Town, State,	and Number	or Rural Rou	ste Number,		
ETED	4 Homicide datarmined							ony or lown, state,					
7	29a. CERTIFIER (Check only 1 CERTIFYING PHYSIC	CIAN: To the best of	my knowledge, der	nth occum	d at the time, d	eta and plac	ca, and dua	to the cause(a) and me	nner aa atat	ed.			
COMPL	one) 2 MEDICAL EXAMINE										and manner se stated.		
ш	296. SIGNATURE AND TITLE OF CERTIFIER		1	4/		29c, LI	CENSE NUI	MBER	29d. DAT	E SIGNED (A	Month, Day, Year)		
00	N /20	nece	e	m	7		75	57	•	3/2	0/93		
2	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETEO CAUS	E OF DEATH /ITEM	1 27) /Time	Oriett					1			

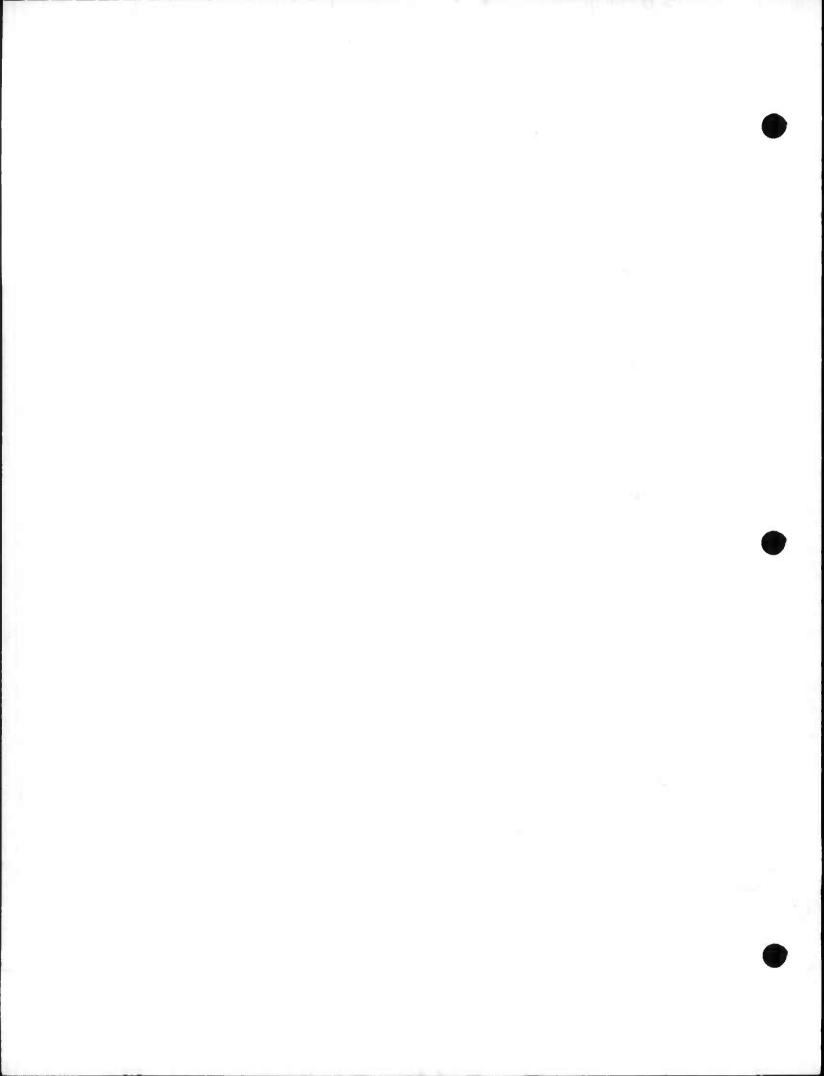
COMPLETEO CAUSE OF DEATH (ITEM 27) (Typo, Print)

Colie

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32. AGGISTRAR'S SIGNATURE
Julia Davidson-Randelle

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	1. DECEDENT'S NAME (First,	Addeddle Looks				ICATI	_ 01	DEAT	-		REG. NO.			
		·	Y - C							2. DATE OF MONTH	DAY		YEAR	TIME OF DEATH
	Rafa 4. SOCIAL SECURITY NUMBER		La Santa	4 405 // 1				. 77.5		03	1	- 17	3	11:30 P M
	582-48-6579		1 M 2 F	6. AGE (In yrs. Is		MONTHS	DAYS	IF UNDER	24 HRS.	7. DATE OF (Month, D	ey, Year)		Country)	MCE (State or Foreign
				58	YRS.					_	15-34	L.	Puert	o Rico
~	9a. FACILITY NAME (If not in			del		9b. CITY	, TOWN O	R LOCATIO	ON OF DE	EATH		9c. COUNT	Y OF DEAT	н
0	Shady Grove	2 Adve	ntist Hos	pita <u>l</u>			Rock	vill	е			Mont	gomer	У
	10a. STATE	10b. COUNT	Υ		10c, C/1	Y, TOWN (	OR LOCAT	ION					40	d. INSIDE CITY
DIRECTOR	Maryland	Mont	gomery			ithe								LIMITS?
AL	10e. STREET AND NUMBER		8011102)		Julia	I CHE.	_	ZIP CODE		_		10- CITIZE		YES 2 NO
	8332 Fairl	naven	Drive					208						COUNTRY
FUNER	11. MARITAL STATUS	101011	12. WAS DECEDENT	EVER IN U.S. A	RMED	13.	WAS DEC			IIC ORIGIN? (S	Procify Yes	USA		American Indian
	1 Never Married 2 X	Married	FORCES? 1 [ IF YES, GIVE WA	YES 2			II yes, spe	cify Cuba	n, Mexica	n, Puerto Rica	n, etc.)	or 140 —   14		American Indian, hite, atc.
B	3 Widowed 4 Divo	read	1 120, 0172 101	IN ON DATES			X YES	2 🗌 NO	Pue	rto Ri	can		Specify:	White
8	15. DEC	EDENT'S EDU highest grade	ICATION	16a. D	ECEDENT'S	USUAL O	CCUPATIO	N .				NESS/INOUS	STRY	marce.
Щ	Elementary/Secondary (0		College (1-4 or 5 +)	- 66	Give kind of e. Do NOT u	work done se retired.)	auring mos	st of workin	g					
<u> </u>	12				Ca	rpen	ter				Self	Emp1	oved	
COMPL	17. FATHER'S NAME (First, Mi	iddle, Last)						18. MOTH	IER'S NA	ME (First, Midd			7	
III	Rafael La	Santa						1	larc	elina	Ro1or	1		
	19a. INFORMANT'S NAME (7)	vpe/Print)		11	96. MAILING	ADDRESS	S (Street a			Poute Number,			ocle)	
2	Nydia LaS	Santa								Gaithe				877
	200. METHOD OF DISPOSITI		Elin sa	20b. PLACE	ANDDATE	OF DISPOS				DATE		ATION — Cit		
	1 X Burial 2 Crematio 4 Donation 5 Other		oval from Stata	cemetery, cr	ematory or o	ther place)	aven	(	3-2	2+93		er Sp		
	21. SIGNATURE OF FUNERAL	L SERVICE LI	CENSEE			22.	NAME AN	D ADORES	S OF FA	CILITY			)I IIIg	
15	Maria	X.	4.4							Funer				20904
- 1	23 PART I From the di	11.0	Jung			$\perp 1$	1800	New	Ham	oshire	Ave.	Silv	er S	pring, MD
	23. PART I. Enter the di shock, or he	sert fellure.	List only one ceus	e on each lin	eeth. Do i	10t enter	the mod	de of dyl	ng, suci	h aa cardlad	or reapin	atory arrea	t,	Approximate interval Between
	IMMEDIATE CAUSE (Fin disease or condition	el		.0	C		1	atte						Onset and Death
	resulting in death)	<b>→</b>	· 340	PATIC OH AS A CONSE	Cn	celan	alo	J OV VIV	y					
				OFF AS A CONSE	OUENCE O	F): \								
N	Sequentially list condition	ons.		OR AS A CONSE	ailu									
ATION	if any, leading to immed cause. Enter UNDERLY!	liate	DO 10 (C	val	OUENCE	F):								
5	CAUSE (Diseese or Inju		c	OR AS A CONSE	OUENCE O									
Ē	that initiated events resulting in death) LAS			i who		r);								
CERTIFICATION			d	20000										
CAL	PART II. Other algnification			eath but not	reculting	in the un	derlying	ceuee g	lven In	Part I. 24	. WAS AN A			RE AUTOPSY FINDINGS
3	Alcol	notis	····							Ι.	PERFORM		co	MPLETION OF CAUSE
										_   '	123 2 [	_	1	DEATH?
W														1123 2   110
N: MEDICAL CE										-				
HAN: ME	25. WAS CASE REFERRED TO	MEOICAL					26. PL	ACE OF OR	ATH (Che	ick only one)				
SICIAN	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO	) MEOICAL	HOSPITAL:	ER/Outpatient :	3 🗆 DOA	OTHER	₹:				an olful			
SICIAN	EXAMINER?	) MEOICAL	1- Inpetient 2 1	YJURY	26b. TIM	4 Nun	R: sing Home 28c. INJU	5 Re		6 Other (S)		JURY OCCUP	RED	
PHYSICIAN	EXAMINER?  1	Pending	1- Inpatient 2 🗆 I	YJURY	26b. TIM	4 🗆 Nun	R: sing Home 28c. INJU WOF	5 G Res	ildence	6 🗆 Other (S)		JURY OCCUP	RED	
BY PHYSICIAN	EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5   1  2 Accident	Pending nvestigation	26s. DATE OF IN (Month, Day,	NJURY ( Year)	26b. TIM	4 - Nun E OF URY M	R: sing Home 28c. INJU WOF 1   Y	F G Red JRY AT RK? ES 2	ildence	6 Other (S)	BE HOW IN			Number
ED BY PHYSICIAN	EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5 1 2 Accident 3 Suicide 6 0	Pending	1- Inpetient 2 1	NJURY ( Year)	26b. TIM	4 - Nun E OF URY M	R: sing Home 28c. INJU WOF 1   Y	F G Red JRY AT RK? ES 2	ildence	6 Other (S) 28d. DESCRI	BE HOW IN			Number,
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BE COMPLETED BY PHYSICIAN	EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5   1 2 Accident  3 Suicide 6   6 4 Homicide  29a. CERTIFIER (Check only one) 2 MEDIC  29b. SIGNATURE AND TILE	Pending newstigation Could not be letermined IFYING PHYSI CAL EXAMINE	26a. DATE OF IN (Month, Day, 28e. PLACE OF building, at	NJURY Year)  INJURY — A1 hr. (Specify)  IN knowledge, demination end/or	26b. TiM INJ orne, farm,	4 Num E OF URY M street, fact	R: sing Home 28c. INJL WOF 1 Y ory, offica	JRY AT RK? ES 2	NO and due	28d. DESCRI 28d. DESCRI 28d. LOCATIC City or R 10 the cause(	DN (Street and who, State)  and mann l place, and	d Number or er as stated. due to the c	Rural Routs Ruse(a) an	d manner es stated.
E COMPLETED BY PHYSICIAN	EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5   1 2 Accident  3 Suicide 6   6 4 Homicide  4 Homicide  29a. CERTIFIER (Check only one) 2 MEDIC  29b. SIGNATURE ANO TILE	Pending novestigation Could not be letarmined IFYING PHYSI CAL EXAMINE OF CERTIFIES	26a. DATE OF IN (Month, Day, 28a. PLACE OF building, at  CIAN: To the best of mr.  R: On the best of axai	NJURY Y Year)  INJURY — A1 h  INJURY	26b. TIM INJ Dome, Tarm, seath occurred investigation	4 Num E OF URY M street, fact	R: sing Home 28c. INJL WOF 1 P Y Oory, office ime, data in plnion, de	p 5 Red RRY AT RK? ES 2 Rand place, eath occurred 29c. LICE	NO NO NO NO NO NO NO NO NO NO NO NO NO N	28d. DESCRI 28d. DESCRI 28d. LOCATIC City or R 10 the cause(	DN (Street and who, State)  and mann l place, and	of Number or er as stated.  due to the company of t	Rural Routs Ruse(a) an	d manner es stated.  nth, Dey, Year)
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REG. NO.

1033357

Montrose Road

29d. DATE SIGNED (Month, Day, Year)

3/19/93

Rockville un

FOR STATE REGISTRAR

31. DATE FILED (Month, Day,

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1. DECEDENT'S NAME (First, Middle, Last)

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MINISION OF VITAL RECORDS, P.O. BOX 68760,	
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		1. DECEDENT'S NAME (First, Middle, Las	r)	-		land		-0	2	DATE OF	DEATH	× .	YEAR	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	t hirthday)	IF UNDER 1 Y	FIE	IF UNDER 24	une 7	DATE OF	Direction 1	8 /	773	PLACE (State or Foreig
2		115-03-6762	1 🗙 M 2 🗆 F	92	YRS.		MYS		B.B.O.	(Month, De	y. Year)	901	Country	TRIA
Should	m	9e. FACILITY NAME (If not institution, give	street and number)			96. CITY, TO	O NWC	R LOCATION				_	TY OF D	EATH
1, 2, 3	DIRECTOR	HEBREW HOME OF G	REATER WAS	SHINGTON		ROCI	KVI	LLE				MO	NTGO	MERY
permit, Pages 1,	IRE	10e. STATE 10b. COUR			10c. CIT	Y, TOWN OR I	LOCAT	ION						10d. INSIDE CITY LIMITS?
mit.		MARYLAND MONT	GOMERY	-	RO	CKVILI	7	ZIP CODE						1X YES 2   NO
Sit De	FUNERAL	6105 MONTROSE RO	ΔD					20852						HAT COUNTRY?
physician. burial-transit	2	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN:						ORIGIN? (S	UNITED ST			- American Indian.
	BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE W	YES 2 XN										
r attending use as the	8	15. DECEDENT'S EI (Specify only highest gra		16a. DE(	16s. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working							SINESS/IND	USTRY	WHITE
4 % P	PLET	Elementary/Secondary (0-12)	College (1-4 or 5+	) life,	ille. Do NOT use retired.)  OWNER					CI	FANT	NG S	TODE	c
the hospit detached once.	COMPL	17. FATHER'S NAME (First, Middle, Last)			WINLIK			18. MOTNES	T'S NAME				TOKE	3
# & &	BE C	WOLF LAWNER							LINE			INKNO	WN)	
retained 1 5 should notified	6	19a. INFORMANT'S NAME (Type/Print)	(D. A. I. C. I. III. III. III. III. III. I			ADDRESS (S								
death. Page 6 may be re tuneral director, page 5 I. examiner must be no		MARLENE STEKERT  20s. METHOD OF DISPOSITION	(DAUGHTE	20b.PLACE A		BILLI			GAI	-	-	, MD		
		X Burial 2 ☐ Cremetion 3X Ra 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	cemetery, crei	matory or or	ther place)		me or	į	3/21	7.00			NEW YORK
		21. SIGNATURE OF FUNERAL SERVICE	DCENSEE	IVELETIC	OD O	22. NAI	ME AN	D ADDRESS	OF FACILI	TY				
9 7 9		Janes 1	m. He	i										ELS, INC. MD 20852
n by reme		23. PART I Enter the diseasas, o ahock, or hear fallun	complications that	csused the de	sth. Do n	ot entar the	a mod	de of dylng	, such a	s cardiac	or respi	ratory arr	est,	Approximate
y filled in the m		IMMEDIATE CAUSE (Finsi disesse or condition	-										Onset and De	
ompletely if, cremat event, t		resulting in death)	a. Sro	DUE TO (OR AS A CONSEQUENCE OF):									days	
P 6 - 6	z			b. In Sluenza									done	
e be execut sician and c orior to bunic traumatic	CATION	Sequentially list conditions, if any, leading to immediate	DUE TO	OR AS A CONSEC	UENCE OF	7):								10093
ficat phy ne p	FICA	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	c	OR AS A CONSEQ	UENCE OF	า.								-
D F B	RTIFI	resulting in death) LAST	d.			,								į
the deaty the attended Mental	CE	PART II. Other algnificant condition	ona contributing to	death but not re	esultino i	n the under	rlylog	cause alw	an In Par	4.1	. WAS AN	ALITOROV		
that that bd b	DICAL	Dementio			ounting .	in the unge	ityirig	csuse giv	en in rai		PERFOR	MEO?	240.	WERE AUTOPSY FINDIN AMAILABLE PRIOR TO COMPLETION DF CAUS
ires sign teal	MED									-   ''	YES 2	LINO		OF OEATH?
has been Dept. of P	AN:													
는 음음 등	SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER:	26. PL	ACE OF DEAT	N (Check	only one)				
SICIAN: The certificate h h the State I	HYS	1 YES 2 X NO 27. MANNER OF OEATN	1 Inpatient 2 I		DOA 28b. TIMI	4 Nursing		5 Resid						
PHy this with	0	1 Natural 5 Pending	(Month, Da	y, Year)	INJ	URY	WOR			G. VEŞCHII	BE NOW IN	IJURY OCC	UHEO	
NOING R: After or death	р ву	3 Suicide 8 Could not be	28e. PLACE OF	INJURY — At hor	ne, farm, s	treet, factory,	office		28	f. LOCATIO	N (Street e.	nd Number	or Rural Ro	oute Number,
OR ATTEND DIRECTOR: / hours after o	ETE	4 Homicide determined		,						Only Or 10				
로독전부	MPL		SICIAN: To the best of r											
TANT.	Ö	2 MEDICAL EXAMI	IER: On the basis of ax	amination end/or in	rveatigatio	n, in my opini	lon, de	ath occured	at the time	e, data and	placa, and	due to the	cause(s)	end manner as stated
The second second		295 SIGNATURE AND TITLE OF CERTIFIC	ED				- 10							

PLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

6121

Musher no

32. REGISTRAR'S SIGNATURE Lina Davidson

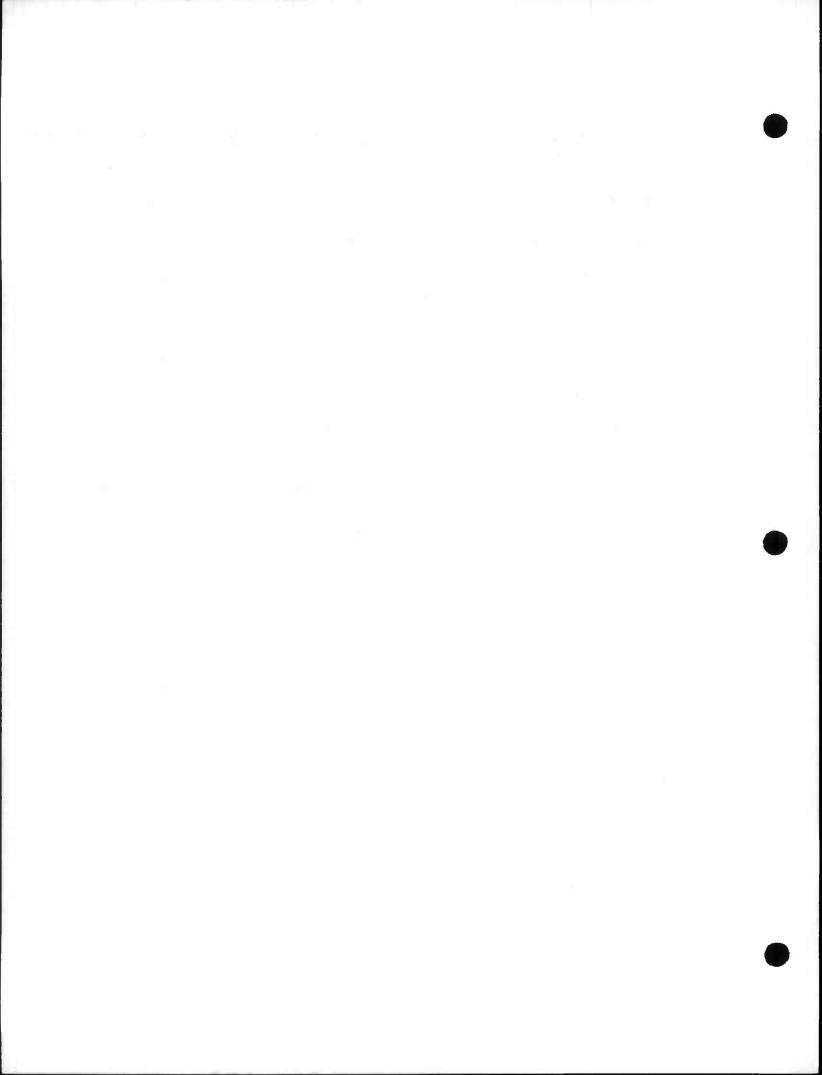
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

93 09722

Interval Between Onset and Death days

24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION DF CAUSE

1:05 Pu



BALTIMORE, MARYLAND 21215-0020	eath. Page 6 may be retained by the hospital or attending physician,	funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 shoul	xaminer must be notified at once.
IISION OF VITAL RECORDS, P.O. BOX 68760,	ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hospital or attending physician.	LILLER: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, ATTENDING PHYSICIAN; The law requires that the

	1 - FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF I		MENTAL HYGIEN		00120
	1. DECEDENT'S NAME (First, Middle, Last)	<del></del>			DEATH	2. DATE OF DEATH		3. TIME OF DEATH
	ANNA B. LEV	WIS				MARCH 23,	1993 YEA	6:59 AM
			'In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BI	RTHPLACE (State or Foreign untry)
	579-10-3210 1  9a. FACILITY NAME (If not institution, give stree		32 YRS.	111111111111111111111111111111111111111	OR LOCATION OF D	MAY 2, 19		AHOMA
DIRECTOR	WASHINGTON ADVENTI		L		A PARK		MONTGO	
REC	10a, STATE 10b, COUNTY		10c. CIT	Y, TOWN OR LOCA	TION			10d. INSIDE CITY LIMITS?
1	MARYLAND MONTGO  100. STREET AND NUMBER	)MERY	SI	LVER SPR				1 YES 2 NO
FUNERAL	1005 KATHRYN ROAD			10	1. ZIP CODE			F WHAT COUNTRY?
Š		2. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DE	20904 CENDENT OF HISPA	NIC ORIGIN? (Specify Yes	USA or No — 14. B	
BY F	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES		If yes, s	ecify Cuban, Maxico 2 NO Speci	nn, Puarto Rican, etc.)	S	ACE — American Indian, lack, Whita, etc. pecify: TTE
9	15. DECEDENT'S EDUCAT (Specify only highest grade cor	(ION (noleted)	16a. DECEDENT'S	USUAL OCCUPATI	ON .	16b. KIND OF BU		
COMPLETED		College (1-4 or 5+)	life. Do NOT us	work done during m se retired.)	ast or working	i		
₩.	17. FATHER'S NAME (First, Middle, Last)	5±	EDITOR	-		NAVY DE		T
	THOMAS FRANK					AME (First, Middle, Maiden		
BE (	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	KATHER	ADULE PL	OEGER	
2	PATRICIA G. LEWIS	(DAUGHTE						AND 20904
	20a. METHOD OF DISPOSITION  1 M Burlal 2 Cremation 3 Ramova 4 Donation 5 Other (Specify)	al from Stata 20b	PLACE AND DATE	OF DISPOSITION (N	arne of	DATE 20c. LO	CATION — City o	Town, Steta
	21. SIGNATURE OF FUNERAL SERVICE LICEN		RLÍNGOTN		L ND ADDRESS OF FA		INGTON,	VIRGINIA
	FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL, SPR., MD. 2090							
	23. PART I. Entar the diseeses, or con ahock, or heart feliure. Lls	npilications that ceused	tha deeth. Do r	not entar the mo	da of dying, aud	h ea cerdiac or reap	iratory arrest,	Approximata interval Between
	IMMEDIATE CAUSE (Final					1		Onset and Daath
	resulting in death)	DUE TO (OR AS A	CONSEQUENCE OF	BLERG		)		Rhours
z	b.	DUE TO (OR AS A MASSILLE	Cuic di	146 1	91197	9		1 han
ATIC	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF	F):	2			
FIC	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	P):	er Kni	anosout.	Mother,	in (See
CERTIFICATION	resulting in death) LAST	DUE TO (OR AS A  COSTILOS SPO  DUE TO (OR AS A  CHRONIC O	1857501	THE AL	knary	disas		( Day II)
AL C	PART II. Other algnificant conditions of	contributing to death be	ut not resulting	in the underlyin	g cause givan in	Part I. 24s. WAS AN		24b, WERE AUTOPSY FINDINGS
SICA	COCTIOSTRONS	depende	1917 RH	anos	of Anyo	PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
ME	Chnoric obson	en pum	any a	lyone			X "	OF DEATH?  1 YES 2 NO
PHYSICIAN: MEDIC								
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IOSPITAL:		26. P	ACE OF DEATH (Ch	eck only one)		
Υ×S	1 YES 2 NO 1	25a. DATE OF INJURY	atlent 3 DOA	4 - Nursing Hon	URY AT	6 Other (Specify)		
	1 Natural 5 Pending	(Month, Day, Year)		URY WO	PRK?	28d. DEŞCRIBE HOW I	NJURY OCCURED	
D BY	3 Suicide 6 Could not be	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm, a	street, factory, offic		28f. LOCATION (Street	and Number or Rui	al Route Number,
ETE	4 Homicide detarmined	Santania, etc. (Spec				City or Town, State)		
COMPLETED		N: To the best of my knowl						
S	2 MEDICAL EXAMINER: C	On the basis of exemination	and/or investigation	n, in my opinion, c	eath occured at the	time, deta and place, an	d due to the caus	e(s) and manner as stated.
H	29b, SIGNATURE AND TITLE OF GENTIFIER	200	()	and	29c. LICENSE NUI	WBER (2006)	29d. DATE SIGN	IED (Month, Day, Year)
은	30. NAME AND ADDRESS OF PERSON WHO C	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type,	Print)	DJa	01	21	25/45
	Michael Barth, M.D.	.,11161 New	Hampshi	re Ave.	Silver	Spring. Ma	d. 2090	)4
	31. DATE FILED (Month, Day, Year) MAR 25 93	Julia Davidse	ATURE CONTACT OF			1	200	

retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 Раде 6 тау

BALT	ours after death.
	24 h
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( 687	se executed within 24 hour
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SECO	aw requires
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5	AN:
OF	PHYSICI
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	OR ATTENDING PHYSICIAN: The 1a
1	OR.

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BE

2

29b. SIGNATURE AND TITLE OF CERTIFIER

A .

31. DATE FILED (Month, Day, MAR 25

RAJ VANSHI

**9**3

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

MO

10313 GEORGIA

32. BEGISTRAP'S SIGNATURE

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH DATE C. MONTH 3 3. TIME OF DEATH Joseph Femand 1230 P.M al 93 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 1 M 2 F 468-42-2039 JAN. 29, 1938 CANADA should 9s. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Pages 1, 2, 3 HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND MONTGOMERY SILVER SPRING 1 | YES 2 | NO permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? use as the burial-transit 1926 FLOWERING TREE TERRACE 20902 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TY YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 TES 2 NO Specify: BΥ Specify: 3 Widowed 4 Divorced 1961-1986 WHITE COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade ĮQ. Elementary/Secondary (0-12) College (1-4 or 5+) 12 detached CE 6 U.S. NAVY once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) funeral director, page 5 should be F OCTAVE LAURIN ANNETTE LAURIN notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 20902 CLAUDINE A. LAURIN FLOWERING TREE (WIFE) 1926 TERRACE SILVER SPRING, MARYLAND Pe 20a. METHOD OF DISPOSITION

1 N Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 28c. LOCATION - City or Town, State DATE must CEMETERY3/24

ARLINGTON NATIONAL CEMETERY3/24 Donation 5 Dother (Specify) ARLINGTON, VIRGINIA examiner 21. SIGNATURE OF GUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL.SPR., MD. 20901 the attending physician and completely filled in by the Mental Hygiene prior to burial, cremation, or removal. the medical 23. PART I. Enter the disessea, or complications that caused the death. Do not enter the mode of dying, auch as cardiec or respiratory arrest, Approximate shock, or heart fellure. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Finel disease or condition \_\_\_\_\_ AMOXIC event, DUE TO (OR AS A CONSEQUENCE OF candiac traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate ocarelia cause. Enter UNDERLYING CAUSE (Disease or injury other that initiated events resulting in death) LAST COVEY 50 PART II. Other significent conditions contributing to death but not resulting in the underlying ceues given in Part i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS certificate has been signed by to the State Dept. of Health and PERFORMED? MAILABLE PRIOR TO any COMPLETION OF CAUSE OF DEATH? 1 | YES 2 | NO Shows 1 YES 2 NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Hem HOSPITAL: OTHER: 1 YES 2 NO 1 Pinpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) this c 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DEŞCRIBE HOW INJURY OCCURED marked. 1 Netural 5 Pending 1 YES 2 NO BY After 2 Accident Investigation 28a. PLACE OF INJURY - At home, farm, street, factory, office 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 69 8 Could not be detarmined DIRECTOR: / COMPLETED 4 🔲 Homicide 28 29a. CERTIFIER
(Chack nnh. 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. FUNERAL WITHIN 72 h = TO THE FLINERA
De Red within 7.
IMPORTANT: 1 2 \_\_\_ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

29c. LICENSE NUMBER

AVE #302

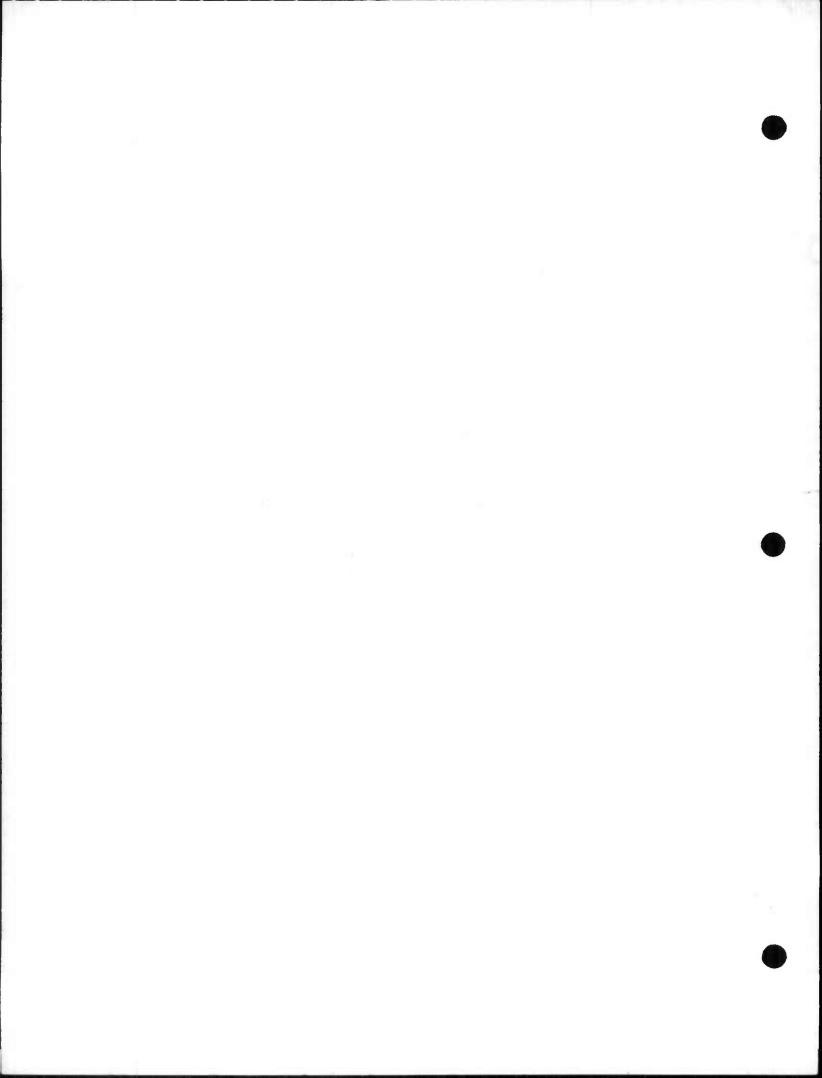
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29d. DATE SIGNED (Month, Day, Year)

mD 2010

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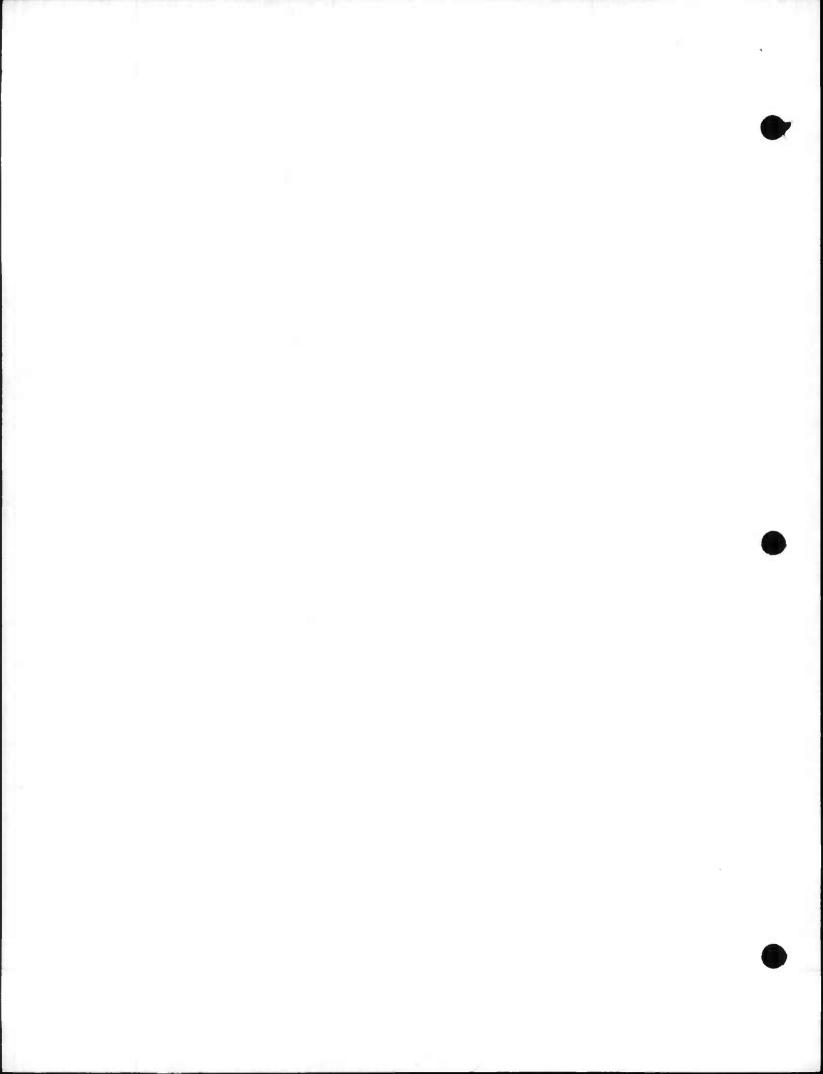
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THE PERTIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR		STATE OF I		/ DEPAR					MENT		_	93	09/25
	1. DECEDENT'S NAME (First, Mid	Idle, Last)	Lowe		ENIII	ICATE	OF	DEA	in_	2. DAT	REG. NO	O ~	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER		5. SEX	8. AGE (In yrs. I	ast birthday)	IF UNDER	1 YEAR	IF UNDE	24 HRS.	7. DAT	E OF BURTH	.0 ~	4. BIRTH	IPLACE (State or Foreign
- 6	220-46-5757		1 🗆 M 2 🖵 F	77	YRS.	MONTHS	DAYS	HOURS	MIN.		nth, Day, Year)	1915	Countr	TH CAROLINA
-	9a. FACILITY NAME (If not institut	tion, give str	eet and number)	14.01	/	9b. CFTY,	TOWN O	R LOCATI	ON OF DE				NTY OF D	
Ę.	RESIDENCE OF DECED	FINE	PITSFT	10spital		KOC	KVI	lle				MOI	NTGON	MERY
DIRECTOR		b. COUNTY			10c. CIT	Y, TOWN O	R LOCAT	ION						10d. INSIDE CITY
1	MARYLAND  10- STREET AND NUMBER	MO	NTGOMERY	<u></u>		ROC	KVI							1 YES 2 NO
FUNERAL	(	c cm n r r	m				10f.	. ZIP COD				10g. CIT		VHAT COUNTRY?
S	13603 SLOAN S	SIREE	12. WAS DECEDEN	IT EVER IN U.S. A	RMED	13. V	MAS DEC		853 Of HISPAN	HC ORK	GIN? (Specify Yes	or No-	USA 14. RACE	E — American Indian.
BY F	1 Never Married 2 Men 3 Widowed 4 Divorced		FORCES? 1 IF YES, GIVE V	YES 2X	NO NO	H	f yes, spe	ecity Cube	in, Mexica Specify	n, Puert	o Rican, etc.)		Black Speci	k, White, etc.
	15. DECEDE		ATION	150.5	DECEDENT'S	LIBITAL OC	SCHBATIO	NA.						HITE
ET.	(Specify only high Elementary/Secondary (0-12)	hest grade o	ompleted) College (1-4 or 5		Give kind of te. Do NOT u	work done d	luring mos	st of world	ng	ľ	6b. KIND OF BU	SINESS/INC	DUSTRY	
COMPLETED	12				HOME	MAKER								
_	17. FATHER'S NAME (First, Middle	El-Lari						18. MOT	HER'S NA	ME (First	, Middle, Maiden	Sumame)		
B	DAVID QUINCY  19a. INFORMANT'S NAME (Type/F		NOR	1,	95 MAILING	ADDRESS	(Street a		ENNI		MING mber, City or Tow	a Chair Ti	0-7-1	
유	EDWIN L. LOWI	-	(HUSE		13603						/ILLE • M			20853
	20a, METHOD OF DISPOSITION			20b. PLACE	E AND DATE	OF DISPOSI	_	_	1			CATION —		
	4 Donation 5 Other (Spe	icify)			IGTON	NATI				3,	/26 ARL	INGTO	Z , NC	/IRGINIA
	22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, INC.													
_	500 UNIVERSITY BLVD. W. SIL SPR. MD. 20901													
	snock, or heart	failure. L	ist only one cau	ise on each iir	na.	not enter	the mod	de of dy	ing, suci	h as ca	irdiac or respi	ratory an	rest,	Approximate Interval Between
	iMMEDIATE CAUSE (Final disease or condition													O A A
	resulting in death)		CAR	NA	n 1	-AI	1_()	1PF	_					Onset and Death
	resulting in death)		CAR	DI A CONS	EQUENCE	FAL	LU	PE	5					Onset and Death
NOI	Sequentially list conditions		SET	OR AS A CONS	EQUENCE O	HO	LU	PRE	3					Onset and Death
CATION	Sequentially list conditions if any, leading to immediate cause. Enter UNDERLYING	0	SET DUE TO ACUT	OR AS A CONS	EQUENCE O	HO	LU Ck M7	) RE	70					Onset and Death
TIFICATION	Sequentially list conditions if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	0	ACUT	OR AS A CONSI	ANC	RE	LU Ck H7	)RE	= 1S					Onset and Death
CERTIFICATION	Sequentially list conditions if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	. { c.	ACUT OUE TO	(OR AS A CONS	ANC EQUENCE O	RE	LU K H7	) RE	75					Onset and Death
AL CERTIFICATION	Sequentially list conditions if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	. { c.	ACUT OUE TO	(OR AS A CONS	ANC EQUENCE O	RE	LU Ck M7	) RE	TS given in	Part i.		AUTOPSY MAED?	24b.	WERE AUTOPSY FINDINGS
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MEDICAL	Sequentially list conditions if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant of the cause of th	conditions  OMI  ARI	ACUT OUE TO	(OR AS A CONS	ANC EQUENCE O	RE	RE TIDI	N,	TS given in	Part i.	PERFOR	MED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?
SICIAN: MEDICAL	Sequentially list conditions if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant of the cause of th	conditions  OMI  ARI	CONTRIBUTING TO A REST	(OR AS A CONS	PANCE OF THE PANCE	in the und	26. PL	ACE OF D	IS given in	-	PERFOF  1 YES 2  One)	MED?	240.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?
SICIAN: MEDICAL	Sequentially list conditions if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant of the cause of th	conditions	CONTRIBUTING TO A REST	OR AS A CONSIDERATION OF THE PROPERTY OF THE P	resulting  Y  3 □ DOA	other 4   Nursi	26. PL	ACE OF D		8 🗆 Ot	PERFOR	(XNO		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?
MEDICAL	Sequentially list conditions if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant of the condition of the cause o	conditions	CONTributing to	death but not provided the state of the stat	resulting  Y  3 DOA  28b. TIM.	OTHER 4   Nursie of Ulry M	26. PL l: ling Home 28c. INJ WOI 1  Y	ACE OF D  5   Re  URY AT  RK?  YES 2	raldence	8 🗆 Ott	PERFOR  1   YES 2	NJURY OC	CUREO	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DE CAUSE OF DEATH?  1 YES 2 NO
ED BY PHYSICIAN: MEDICAL	Sequentially list conditions if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant of the condition of the cause o	c. d. d. d. d. d. d. d. d. d. d. d. d. d.	CONTRIBUTION TO THE PLAN CONTRIBUTION TO THE P	OR AS A CONSIDERATION OF THE PROPERTY OF THE P	resulting  Y  3 DOA  28b. TIM.	OTHER 4   Nursie of Ulry M	26. PL l: ling Home 28c. INJ WOI 1  Y	ACE OF D  5   Re  URY AT  RK?  YES 2	raldence	8  Ott	PERFOF  1  YES 2  one)  her (Specify)	NJURY OC	CUREO	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DE CAUSE OF DEATH?  1 YES 2 NO
ED BY PHYSICIAN: MEDICAL	Sequentially list conditions if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant of the cause of th	conditions  ColCAL  ding  dispetion  d not be  mined	CONTRIBUTION TO THE PLAN CONTRIBUTION TO THE P	(OR AS A CONSIDERATION OF INJURY AT INJURY of Inc. (Specify)	resulting  Y  3 DOA  28b. TIM  Norme, farm,	OTHER 4   Nursi E OF   Nursi E of   Nursi E	26. PL i: ing Home 28c. INJL WOI 1  Y	ACE OF D  5 G  Rev  URY AT  RK?  YES 2	NO	8 Ottl 28d. O	PERFOR  1  YES 2  one)  her (Specify)  ESCRIBE HOW I  CATION (Street or Town, State)	NJURY Oct	CUREO	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DE CAUSE OF DEATH?  1 YES 2 NO
ED BY PHYSICIAN: MEDICAL	Sequentially list conditions if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant of the condition of the cause o	conditions  ColCAL  Solid not be remined	CONTRIBUTION OUE TO  CONTRIBUT	(OR AS A CONSI  death but not  PATO  ER/Outpetlere  INJURY  wy, Yber)  Tribuny  Trib	resulting  Y  3 DOA  28b. TIM  Norme, farm,	OTHER 4   Nursie OF   Nursie Of   Nursie of at the tired, facto	26. PL l: ling Home 28c. INJ WOI 1 Y Ory, offica	ACE OF D  5  R  URY AT  RK?  ES 2   end place	NO NO end due	8 Ott 28d. O	PERFOR  1 VES 2  one)  her (Specify)  ESCRIBE HOW I  CATION (Street of your Town, State)	NJURY Oceand Number	CUREO  r or Rural R	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DE CAUSE OF DEATH?  1 YES 2 NO
E COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant of the condition of the cause o	c. d. d. d. d. d. d. d. d. d. d. d. d. d.	CONTRIBUTION OUE TO  CONTRIBUT	(OR AS A CONSI  death but not  PATO  ER/Outpetlere  INJURY  wy, Yber)  Tribuny  Trib	resulting  Y  3 DOA  28b. TIM  Norme, farm,	OTHER 4   Nursie OF   Nursie Of   Nursie of at the tired, facto	26. PL l: ling Home 28c. INJ WOI 1 Y Ory, offica	ACE OF D  5 GR  URY AT RK?  ES 2 G  end place seth occur	NO NO end due	8 Ott 28d. O	PERFOR  1 VES 2  one)  her (Specify)  ESCRIBE HOW I  CATION (Street of your Town, State)	NJURY Octored Number	CUREO  r or Rural R  ted.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
BE COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant of the condition of the cause o	conditions  Condit	CONTRIBUTION TO THE PARTY OF TH	(OR AS A CONSI  death but not  ATOM  BENOUTpetient  INJURY  FINJURY — At hete. (Specify)  my knowledge, c  xamination end/or	resulting  Y  3 DOA  28b. TIM  Noome, farm,	OTHER 4   Nursi	26. PL l: ling Home 28c. INJ WOI 1 Y Ory, offica	ACE OF D  5 GR  URY AT RK?  ES 2 G  end place seth occur	NO NO not due	8 Ott 28d. O	PERFOR  1 VES 2  one)  her (Specify)  ESCRIBE HOW I  CATION (Street of your Town, State)	NJURY Octored Number	CUREO  r or Rural R  ted.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DE CAUSE OF DEATH?  1 YES 2 NO  Route Number;
E COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant of the condition of the cause o	conditions  condit	CONTRIBUTION TO THE PARTY OF TH	(OR AS A CONSI  death but not  PATO  ER/Outpetlere  INJURY  wy, Yber)  Tribuny  Trib	resulting  Y  3 DOA  28b. TIM  Noome, farm,	OTHER 4   Nursi	26. PL l: ling Home 28c. INJ WOI 1 Y Ory, offica	ACE OF D  5 GR  URY AT RK?  ES 2 G  end place seth occur	NO NO not due	8 Ott 28d. O	PERFOR  1 VES 2  one)  her (Specify)  ESCRIBE HOW I  CATION (Street of your Town, State)	NJURY Octored Number	CUREO  r or Rural R  ted.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DE CAUSE OF DEATH?  1 YES 2 NO  Route Number;



FOR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCIENE

1 - STATE REGISTRAR				OF DEA		REG. NO	_		
1. DECEDENT'S NAME (First, Middle, Last) Elmer Jos	seph Larmor			<u> </u>		2. DATE OF DEATH	AY YE	3. TIME C	F DEATH
4. SOCIAL SECURITY NUMBER	1					3 1			
220-26-1475	5. SEX 6. AGI	E (In yrs. lest birthday O YRS.		YEAR IF UNDI	MIN.	7. DATE OF BIRTH (Month, Day, Year) 7-1-193		BIRTHPLACE (SN Country) Maryla	
9a. FACILITY NAME (If not institution, give	street and number)		9b. CITY, 1	OWN OR LOCA	TION OF D		9c. COUNTY		
Memorial Hospi: RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT Maryland Ta	tal at Easto	n	Eas	ton			Talbo	ot	
10a. STATE 10b. COUNT		10c. C	ITY, TOWN OR	LOCATION				10d. INSIG	
Maryland Ta	albot	E	astor	1				1 TYES	2 X NO
100. STREET AND NUMBER  8981 Treesdale  11. MARITAL STATUS	e Drive	· •		10f. ZIP COI	601		10g. CITIZEN	OF WHAT COUN	ITRY?
11. MARITAL STATUS	12. WAS DECEDENT EVER FORCES? 1 YES	IN U.S. ABMED	13. W			NIC ORIGIN? (Specify Yes		RACE — Americ	en Indien
3 Widowed 4 Divorced	FORCES? 1 YES	S 2 XNO DATES	11	yes, specify Cut	osn, Mexica	in, Puerto Ricen, etc.)		Specify: White, etc.	2.
15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12) 1.1 17. FATHER'S NAME (First, Middle, Last)	JCATION .	16a. DECEDENT	S USUAL OCC	UPATION		16b. KIND OF BU	SINESS/INDUST		
Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT	f work done du use retired.)	ring most of work	king				
11		Cus	todia	n		Easton	Midd	le Sch	ool
17. FATHER'S NAME (First, Middle, Last)				18. MO	THER'S NA	ME (First, Middle, Malden	Surname)		
George Elwood  19a. INFDRMANT'S NAME (Type/Print)	Larmore	programme.				che I. B			
Pamela J. Ross						Route Number, City or Tow			1
20a METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Ran 4 Donation 5 Other (Specify)	novel from State	DE PLACE AND DATE	FOFOISPOSIT	ON (Name of		0ATE 20c. LO 3-16 Eas	CATION CIN	or Town State	
	DENSEE	Spring	22. N/	ME AND ADDR	ery ESS OF FA	3-16 Eas	ton,	WD 516	01
B. Keith	Physics,	CFSF	Ne	wnam	Fune	eral Home	P.A	ton W	D 216
23. PART I. Enter the diseases, or	complications that cause	ed the dasth. Do		ne mode of d	ying, suc	h as cardiac or resp	ratory arreat,	App	roximata
IMMEDIATE CALISE (Final	a. PNEUTUS DUE TO (OR AS								rval Between et and Death
resulting in death)	DUE TO (OR AS	A CONSEDUENCE	OF):						11/
	· ASPIRA	TIEN	GASTI	215	CONT	TO LUN		13/7	193
Sequantially list conditions, if any, leading to immediate		A CONSEDUENCE	DF):		. 1	7 1 110	2	11/	1
Cause, Enter UNDERLYING CAUSE (Disease or Injury	c				(10	0 2010			
that initiated events resulting in death) LAST	DUE TO (DR AS	A CONSEQUENCE	OF):						
resoluting in Galatti) Exst	d								
PART II. Other significent condition	na contributing to death	but not reaulting	in the unda	arlying cause	given in	Part I. 24s. WAS AN	AUTOPSY	24b. WERE AUTO	OPSY FINDINGS
DIABE	TIES, Hypo	SELYCE	TiA.		-	PERFOR	IMED?	AWAILABLE	
	CEN	ESCOI	53	SAA		1 YES 2	I NO	OF DEATH?	
	STATUS	TPILI	- 121	C15	•	_	i i	1 NES	2   ND
25. WAS CASE REFERRED TO MEDICAL	01/11/03	1416	4) [	26. PLACE OF	DEATH (Ch	eck cah can)			
EXAMINER?  1 YES 2 YND	HOSPITAL:	tostlent 3 🗆 DOA	OTHER:					-	
27. MANNER OF DEATH	28a. DATE OF INJURY			g Home 5   F	lasidenca	8 Other (Specify) 28d. DESCRIBE HOW I	H ILIBA OCCIDE		
1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)		JURY	WORK?	□ ND	200. DESCRIBE NOW I	NOONT OCCUME		
3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJUR building, etc. (Sp	RY — At home, farm, ecify)	street, factor	r, office		281. LOCATION (Street & City or Town, State)	and Number or R	ural Route Numbe	ς
29a. CERTIFIER Check only	ICIAN: To the best of my kno	wledge, daeth occur	red at the time	, data and plac	s, and dus	to the cause(a) and mar	nner as stated.		
one) 2 MEDICAL EXAMINI	ER: On the basis of examineti	on and/or investigat	lon, in my opi	nion, death occu	ured at the	time, data and place, an	d due to the ce	use(s) and mann	er as stated.
29b. SIGNATURE AND TITLE OF CERTIFIE	Rom DD	C.RW	BAIN	1D 29c. LIC	ENSE NUM	ABER 50	29d. DATE SIG	IZ 192	( Year)
30. NAME AND ADDRESS OF PERSON WHO		EATH STEM OF CE	- Dilan				. 01	113	
			11-21 2,	1 . 0	1	- (	<u> </u>		
MAR 1 1993	32. REGISTRAR'S SIG	AL THE							

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death, Page 6 may be retained by the hospital or attending physician.	After This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detacted for use as the burial-transit nermit. Panes 1 2 should	Journal after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
THE JOSPITAL OR ATTENDE	THE FUNETAL DIRECTOR: A	s filed within 72, Jours after de	APORTANT: If item 28 is

										(	93	09727
	1 - FOR STATE REGISTRAR	STATE OF M	ARYLAND /	DEPAR ERTIF	TMEN ICATI	T OF HE	EALTH DEAT	AND N	MENTAL HYGIEN REG. NO	E		03121
	1. DECEDENT'S NAME (First, Middle, Last)					_			2. DATE OF DEATH			3. TIME OF DEATH
	Amedeo	John I	Lombard	i					3 16	19	93	12:35A M
	4. SOCIAL SECURITY NUMBER	55.0	8. AGE (In yrs. les	t birthday)	IF UNDER		IF UNDER		7. DATE OF BIRTH (Month, Day, Year)			PLACE (State or Foreign
		1 X M 2 □ F	82	YRS.	MONTHS	DAYS	HOURS	MIN.	2-6-191	1		yland
- C	9a. FACILITY NAME (If not institution, give stre	set and number)			9b. CITY	, TOWN OF	LOCATIO	ON OF DE	ATH	9c. COU	NTY OF DE	
DIRECTOR	Memorial Hospita	ıl at Eas	ton		E	astor	1			Ta1	bot	
당	RESIDENCE OF DECEDENT  10e. STATE 10b. COUNTY					OR LOCATIO						
E	Maryland Tall	hot			stor		ON					10d. INSIDE CITY LIMITS?
	100. STREET AND NUMBER	DOT		Las	SUOI		ZIP CODE					1 YES 2 XNO
A A	124 Park Lane	9632 н	wdo Do	nk		101.		1601		10g. CIT		HAT COUNTRY?
FUNERAL					12	Wile DECE			IC ORIGIN? (Specify Yes		USA	
	1 Never Merried 2 X Married	12. WAS DECEDENT. FORCES? 1 [ IF YES, GIVE WA	YES 2 N	10		If yes, spec	cify Cuban	n, Mexicar	n, Puerto Ricen, etc.)	or No-		— American Indian, White, etc.
ВУ	3 Widowed 4 Divorced	W TES, GIVE WA	N ON DAIES			1 TYES 2	Z (XNO	Specify.			Specifi	ite
COMPLETED	15. DECEDENT'S EOUCA (Specify only highest grade of	ATION COMPONENTS	16a. DE:	CEDENT'S	USUAL O	CCUPATION	V .		16b. KIND OF BUS	SINESS/IND		
9	Elementary/Secondary (0-12)	College (1-4 or 5 +)				during most						
MP	12		Man	agei	r-Me	eat I	Dept	t	Acme			
8	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	IER'S NAM	ME (First, Middle, Malden	Surname)		
BE	Anthony Lomba	rdi							es "unkno			
2	19a. INFORMANT'S NAME (Type/Print)	mh d -	198	MAILING	ADDRES:	S (Street and	d Number	or Rural R	loute Number, City or Tow	n, State, Zip	Code)	
-	Carolyn R. Lor							, 96	32 Hyde	Par	k, E	aston,MD
	20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Remov	val from State	20b. PLACE A cemetery, cres	metary or of	her niecel						City or Tov	
	4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LICE	Neer	Md. V	eter	rans	S Cer	mete	ery	3-19 Be	eula	h, M	D
	The state of the take service side	NJEE				NAME AND			eral Home	D	Δ	
	JOHN R	MERCE	RON	CFSI	$\geq \mid 2 \mid$	3 008	S. E	Iarr	rison St.	. E:	asto	n, MD
	23. PART i. Enter the diseases, or co shock, or heart failure. Li	emplications that	caused the de	ath. Do n	ot entar	tha mod	e of dylr	ng, auch	aa cardiac or reapi	ratory an	reat,	Approximata
	IMMEDIATE CAUSE (Final	0	_	1 4		- 1	(	)				Intarval Between Onset and Death
	disease or condition	100	20mg	Hu	X	K	ril	eur	ع			
1 1		· — — — —	-11									
		DUE TO (C	OR AS A CONSEC	DUENCE OF	0:()	0	1000					00
NO	Sequentially list conditions,	Pa	Que	na	u	. 6		e	mbol	2us		alus.
ATION	Sequentially list conditions, if any, laading to immediate	Pa	OR AS A CONSECUTION AS	na	u	(6)		. l	mbol	2us		9 Pms.
FICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO 10	M AS A CONSEC	WENCE OF	*				mbol	Pus		alus.
RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO 10	Que	WENCE OF	*				u bol	<u>Cus</u>		alus.
CERTIFICATION	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (C	OR AS A CONSECU	DUENCE OF	*			Q	mbr	2us		alus.
O	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (C	OR AS A CONSECU	DUENCE OF	*	nderlying	cause g	Q Iven in I	Part I. 24s. WAS AN			WERE AUTOPSY FINDINGS
O	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (C	OR AS A CONSECU	DUENCE OF	*	nderlying	cause gi	Iven in I	Part I. 24s. WAS AN PERFOR			WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE
O	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (C	OR AS A CONSECU	DUENCE OF	*	nderlying fra ci.	cause gi	liven in F	PERFOR			WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDICAL C	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (C	OR AS A CONSECU	DUENCE OF	*	nderlying	cause gi	liven in I	PERFOR			WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE
MEDICAL C	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other aignificant conditions  ASSUMED TO MEDICAL  28. WAS CASE REPERRED TO MEDICAL	DUE TO (C	OR AS A CONSECU	DUENCE OF	n tha ur	frici.	eu o	of E	PERFOR			WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDICAL C	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions  ASSUMED CONTROL CONDITIONS  25. WAS CASE REFERRED TO MEDICAL EXAMINERTY	DUE TO (C	OR AS A CONSECUENT OF THE PROPERTY OF THE PROP	DUENCE OF	n tha ur	frei in	RU C	Tels	PERFOR			WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDICAL C	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other eignificant conditions  Was case referred to medical.  EXAMINERT OF CEATH	DUE TO (C	PROMpatient 2	DUENCE OF	or Her	frei in	CE OF DE	Tels	PERFOR	Мерт		WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDICAL C	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions  ASSUMED TO MEDICAL EXAMINERY  1 YES 2 NO	DUE TO (C	PROMpatient 2	DOA 200, TIME	or Her	25. PLAI R: sing Home 28c. INJUI	CE OF DE	ATH (Che	PERFOR	Мерт		WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
D BY PHYSICIAN: MEDICAL C	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions  While the significant conditions  21. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  Noturn 5 Pending Investigation  3 Stuicide 5 Could not be	DUE TO (C)  Contributing to d  CONTRIBUTION (C)	PR AS A CONSECUTION OF AS	DOA 200. TIME	OTHER	25. PLA R: sing Home 28c, INJUI WORL 1 YE	CE OF DE	ATH (Che	PERFOR	MED? NO	CURRED	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
ED BY PHYSICIAN: MEDICAL C	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions  PART II. Other significant conditions  21. WAS CASE REPERRED TO MEDICAL EXAMINERY  1 YES 2 NO  22. MANNER OF DEATH  Natural 5 Pending Investigation  3 Suicide 6 Could not be determined	DUE TO (C  DUE TO (C)  Contributing to d  CONTRIBUTING TO (C)  CONTRIBUTION (C)  CON	PR AS A CONSECUTION OF AS	DOA 200. TIME	OTHER	25. PLA R: sing Home 28c, INJUI WORL 1 YE	CE OF DE	ATH (Che	PERFOR  1 VES 2  AND OTHER (Specify)  284, DESCRIBE HOW II	MED? NO	CURRED	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
ED BY PHYSICIAN: MEDICAL C	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other eignificant conditions  PART II. Other eignificant conditions  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF CEATH  Notural 5 Pending Investigation 3 Stuicide 8 Could not be determined  29s. CERTIFIER Check only	DUE TO (C  DUE TO (C)  Contributing to d  CONTRIBUTION CO	eath but not received a suppression of the consequence of the conseque	DOA 280, TIME	OTHER	25. PLAN R: sling Home 29c. INJUIL 1 YE tory, office	CE OF DE  3	ATH (Character I NO and due to	PERFOR  1 VES 2  Other (Specify)  28d. DESCRIBE HOW 8  28f. LOCATION (Street a City or Rent, State)	MED? NO  NUMBER OCC	CURRED or Plural Rel	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
ED BY PHYSICIAN: MEDICAL C	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other eignificant conditions  PART II. Other eignificant conditions  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF CEATH  Accident  3 Suicide 5 Could not be determined	DUE TO (C  DUE TO (C)  Contributing to d  CONTRIBUTION (C)  CONTRI	eath but not received a suppression of the consequence of the conseque	DOA 280, TIME	OTHER	25. PLAN R: sling Home 29c. INJUIL 1 YE tory, office	CE OF DE  3	ATH (Character I NO and due to	PERFOR  1 VES 2  Other (Specify)  28d. DESCRIBE HOW 8  28f. LOCATION (Street a City or Rent, State)	MED? NO  NUMBER OCC	CURRED or Plural Rel	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
E COMPLETED BY PHYSICIAN: MEDICAL C	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other eignificant conditions  PART II. Other eignificant conditions  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF CEATH  Notural 5 Pending Investigation 3 Stuicide 8 Could not be determined  29s. CERTIFIER Check only	DUE TO (C  DUE TO (C)  Contributing to d  CONTRIBUTION (C)  CONTRI	eath but not received a suppression of the consequence of the conseque	DOA 280, TIME	OTHER	28. FLAI 1: 1 YE 1 YE 1 YE 1 YE 1 YE 1 YE 1 YE 1 YE	CE OF DE  3	ATH (Che sidence I No and due to det the t	Ck only one:    The color of th	MED? NO  NUMBER OCCUPANT Another on state of due to the	or Flural Fig.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
COMPLETED BY PHYSICIAN: MEDICAL C	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions  PART II. Other significant conditions  25. WAS CASE REFERRED TO MEDICAL EXAMINER:  1 YES 2 NO  27. MANNER OF CEATH  1 Hours 5 Pending Investigation  3 Suicide 6 Could not be determined  29s. CERTIFIER (Check only one)  2 MEDICAL EXAMINER:	DUE TO (C  DUE TO (C)  Contributing to d  CONTRIBUTION (C)  CONTRI	eath but not received a suppression of the consequence of the conseque	DOA 280, TIME	OTHER	28. FLAI 1: 1 YE 1 YE 1 YE 1 YE 1 YE 1 YE 1 YE 1 YE	CE OF DE	ATH (Che sidence I No and due to det the t	Ck only one:    The color of th	MED? NO  NUMBER OCCUPANT Another on state of due to the	or Flural Fig.	WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO

1993

m.D

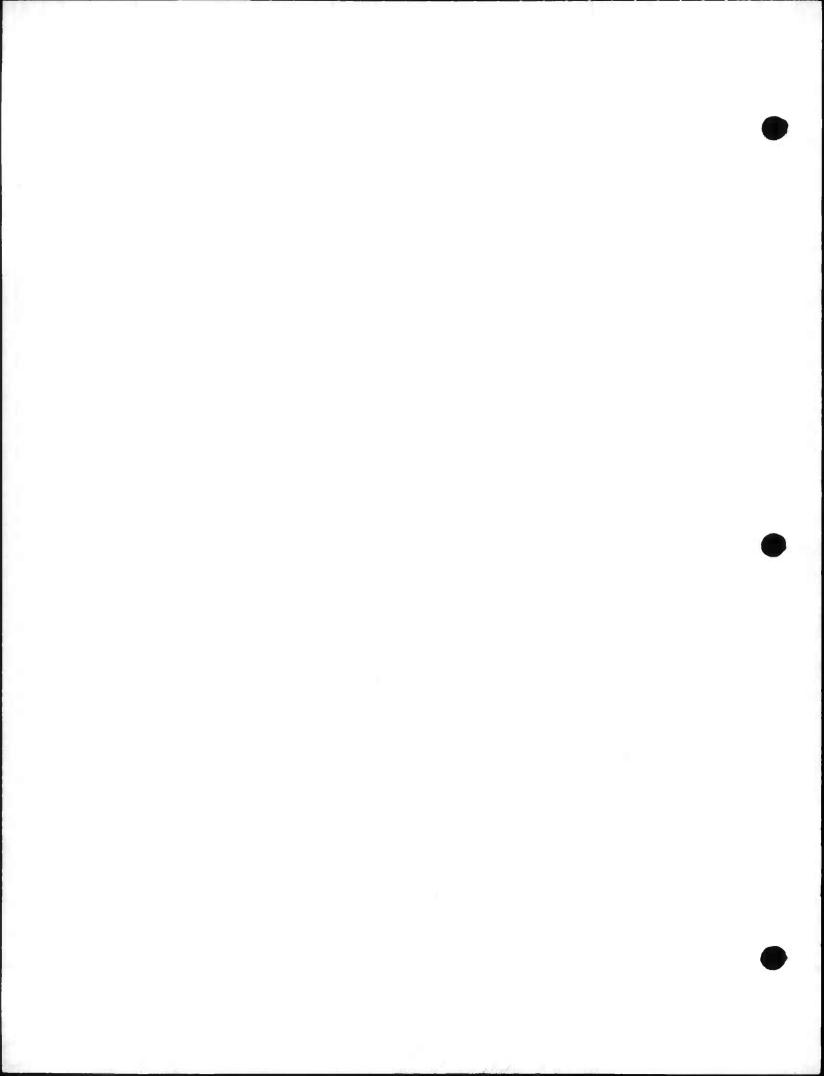
AND

508 IDLEWILD BASIN MARIN

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

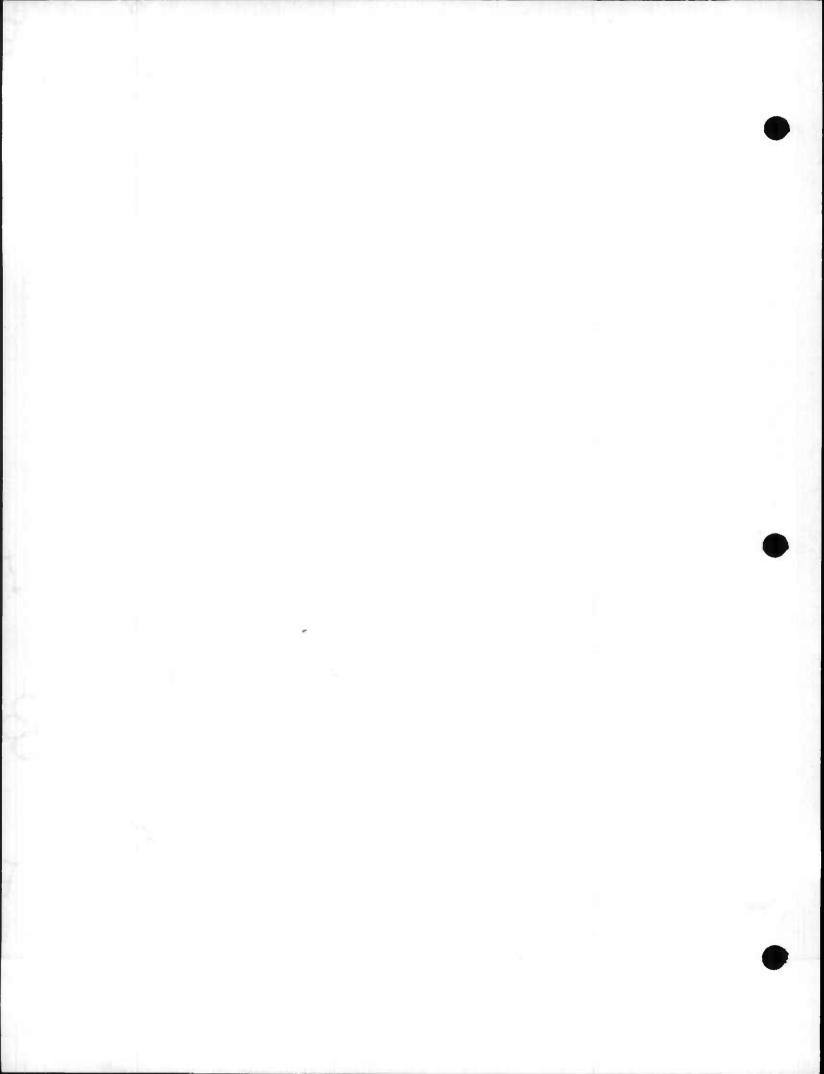
REG NO

10.0		HEGISTHAN			OLITIII	IOAIL	. 01	DEATH	1	REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Lest)  MARGIE	P.		LAURENC	CE				MARCH 17	199	YEAR 3	3. TIME OF DEATH 8:30PM
		4. SOCIAL SECURITY NUMBER 271-24-5439	5. SEX		(In yrs. last birthday)	IF UNDER	1 YEAR	IF UNDER 24 I		7. DATE OF BIRTH (Month, Day, Ybar)		Country	PLACE (State or Foreign
身			1 M 2 TF		OU YRS.				P	lug. 28,			
2, 3 should	OR	9e. FACILITY NAME (If not institution, give si 16076 A.E. MULL		•			DAI	SY	OF DEA	гн		HOWA	
+-	اق	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY											
permit. Pages	DIRECTOR	MD EX	PRINCE	GE	ORGES	T, IUWN U	H LOCA	LAURE	EL				10d. INSIDE CITY LIMITS? 1 YES 2 NO
, ig	FUNERAL	100. STREET AND NUMBER 4803 DAVRON ST	REET				10	2070	7			S.A.	HAT COUNTRY?
020 physician. burlal-transit	5	11. MARITAL STATUS	12. WAS DECEDENT			13. \	MAS DE	CENDENT OF H	HISPANIC	ORIGIN? (Specify Yes		14. RACE	- American Indian.
21215-0020 If or attending physician for use as the burial-train	B	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 IF YES, GIVE W					S 2 NO		Puerto Rican, etc.)	serto Rican, etc.)  Black, White, etc.  Specify:  WH		
121(	뎶	15. DECEDENT'S EDUC (Specify only highest grade			16a. DECEDENT'S	work done o	CUPATI	ION lost of working		16b. KIND OF BUS	SINESS/IND	USTRY	
1 = 5	APLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	,	REGISTRAR					S.D.A.			
YLAND by the hospit be detached at once.	BE COMPL	17. FATHER'S NAME (First, Middle, Lest)	TIIMM		-					E (First, Middle, Meiden			
RYL ed by		ALFRED LUTTRELL ELLEN BASH  19a. INFORMANT'S NAME (Type/Print)  19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, S											
E, MARYLAND y be retained by the hospit age 5 should be detached be notified at once.	9	J.P.LAURENCE				AME Z			Aural Ro	ute Number, City or Tow	n, State, Zip	Code)	
FOR ector, p	ĝ.	20s. METHOD OF DISPOSITION 1/S Burlal 2 Cremation 3 Remote Control of Control	ovel from State	Cen	PLACE AND DATE	ther placel			Cem	OATE 200. LO	cation =		
ALTIMO death. Page 6 e funeral directe al.	- 3	21, SIGNATURE OF FUNERAL BERVICE VIO	ENSEE	1	ſ	22.	NAME A	NO ADDRESS	OF FACI	LITY			CARROLL
0 = 0		Muchan	1000	2	Ju	ST	. 1	V.W. W	WASI	HINGTON,	D.C	2. 2	
in 24 hours by filled in lation, or ra		23. PART I. Enter the diseases, or o shock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	List only one caus	e on e	ach line.								Approximate interval Between Onset and Death
P 8 5 - 6	Z	Compatibility list conditions	disease or condition resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):										
	ATIC	oue to (DR AS A CONSEQUENCE OF):  If any, leading to immediate cause. Enter UNDERLYING  CALIFE CHARACTER OF THE CAUSE OF T										10 this	
P.O. BOX th certificate be e tending physician is il Hygiene prior to or other traum	RTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST										1000	
OS, P. Os death of the attendit Mental Hy	8		1										
RDS, I at the deat by the atte and Mental y injury.	A.	PART ii. Other significent condition	1		out not resulting	in the un	derlyin	ng ceuse give	en in Pa	ort i. 24a. WAS AN PERFOR			WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
CORDS, uires that the dea signed by the att Health and Menti we any injury,	EDICAL	<i>6.3</i> 7	ex cot	nt	15					1 YES 2			COMPLETION OF CAUSE OF DEATH?
	2									-			1 TES 2 NO
ITAL RE IT The law required to the law seen state Dept. of Hitem 23 show	AN	25. WAS CASE REFERRED TO MEDICAL					26. P	LACE OF DEAT	TH (Checi	k only one)			
NE VITAL RE rSiCIAN: The law requi s certificate has been s th the State Dept, of H d, or item 23 show	SIC	EXAMINER?	HOSPITAL:	ER/Outp	patient 3 DOA	OTHER 4 IN Num	R;			Other (Specify)	-		
O E # # 8	Y PHYSICIAN:	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE DF I (Month, Da		285. TIM	-	The IN.	JURY AT ORK? YES 2 N		Red. DESCRIBE HOW I	NJURY OCC	CUREO	
TENDING CIDH Mer SE IS Man	ED BY	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. PLACE OF building, a	INJURY	— Al home form,	gtreet, facto			-	281. LOCATION (Street a City or Town, State)	and Number	or Rural Ro	oute Number,
Item Item	E	29a. CERTIFIER (Check only	CIAN: To the heat of a	my kraow	ledge death occur	ad at the ti	ma dete	a and alone on	of above to	the country and man			
三 引起 五	COMPLET	(Check only one) 2 MEDICAL EXAMINE											and manner as stated.
TO THE HOSE TO THE FUNE De filed within	H	29b. SIGNATURE AND TITLE OF CERTIFIER	8 0.7		4-			29c, LICENS	100	798	<b>b</b> 4	7 10	(Month, Day, Year)
₽ ₽ 2 €	2	30. NAME AND ADDRESS OF PERSON WHI	COMPLETEO CAUS	E OF DE	ATH (ITEM 27) (Type	, Print)				,,-	-	-/ 9	, /3
		31. DATE FILED (Month, Day, Year)	SAN, DS	ppe	My XU	77	0/	City	21/	gre TK	PK.	MI	20912
		MAR 22 '93	Julia D	wids	- Rondall						/		



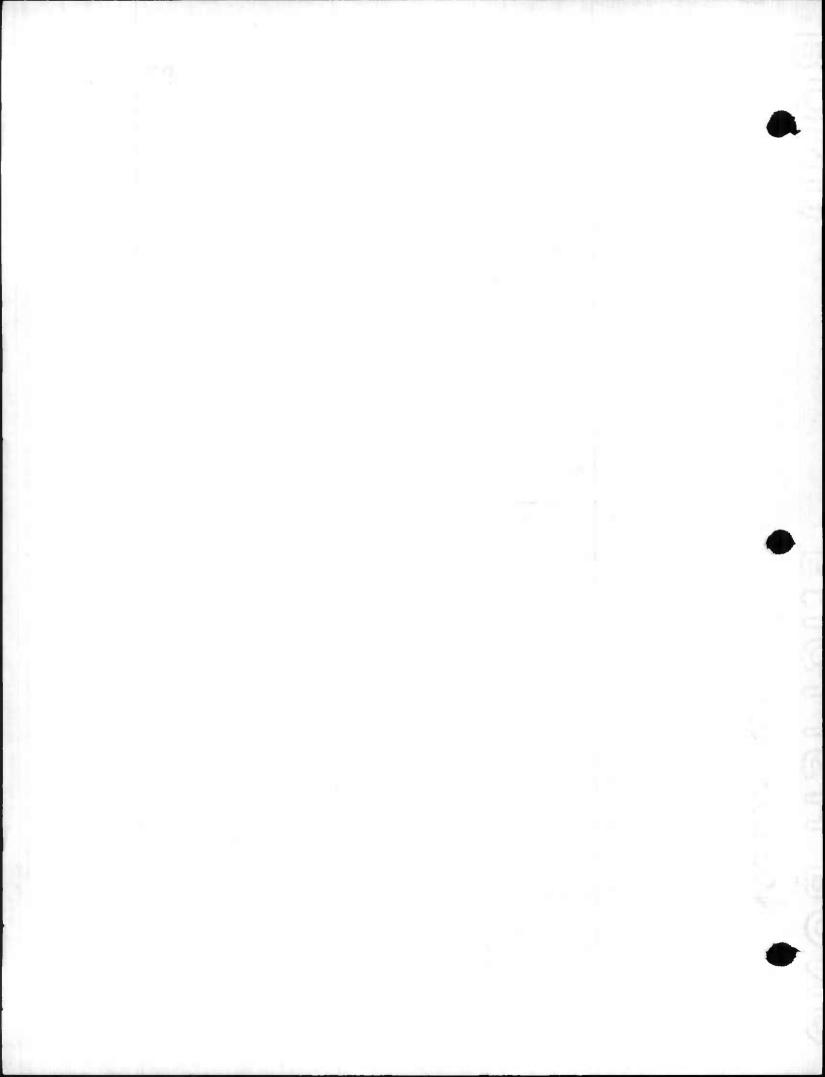
	des 1, 2, 3 should		
or attending physician.	r use as the burial-transit permit. Pages 1, 2,		
may be retained by the hospital	VERTION: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the		ist be notified at once.
n 24 indus arter bearn. Page b	ly filled in by the funeral director	ation, or removal.	IT. II item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must b
IIII Certificate de executed with	tending physician and complete	al Hygiene prior to burial, crem	or other traumatic event,
The law requires that the dea	ate has been signed by the att	death with the State Dept. of Health and Mental Hygiene prior to	tem 23 shows any Injury,
L UR ALLENDING PHYSICIAN.	AL DIRECTOR: After this certific.	In 72 hours after death with the St	Il item 28 is marked, or il
÷	4	5	E

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	AND / DEPARTM CERTIFIC			MENTAL HYGIEN			03163		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH			3. TIME OF DEATH		
	CHESTER L	LI	ERKINS			MARCH 18	AY 8. 1	993	9:45 P M		
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (II		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)			IPLACE (State or Foreign		
	128-05-7274	1 XM 2 □ F 85	YRS.	NTHS DAYS	HOURS MIN.		1907		York		
	9a. FACILITY NAME (If not institution, give street	et and number)	91	CITY, TOWN O	R LOCATION OF DE		9c. COU	NTY OF D	EATH		
DIRECTOR	11103 Stillwater	Road		Kensir	gton		Mon	taom	erv		
<u> </u>	10a. STATE 10b. COUNTY		10c, CITY, T	OWN OR LOCAT	ION			100	10d, INSIDE CITY		
H	New Jersey Ocea	an.	Brick						LIMITS?		
	10g. STREET AND NUMBER	u 1	BIIC		ZIP CODE		10g. CIT	IZEN OF V	WHAT COUNTRY?		
ER/	118 Whittier Road				8724		Uni	ted	States		
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DEC	ENDENT OF HISPAN	IIC ORIGIN? (Specify Ye			E — American Indian,		
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	TES		2 NO Specify	n, Puerto Rican, etc.)		Speci			
			II						White		
	15. DECEDENT'S EDUCA (Specify only highest grade co	ompleted)	(Give kind of work life. Do NOT use re	UAL OCCUPATION  done during modelined )	N st of working	16b. KIND OF BU	SINESS/INC	DUSTRY			
2	Elementary/Secondary (0-12)	College (1-4 or 5+)	Part-Own			Shoe Ma	anufa	otur	or		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		Tart-own		16. MOTHER'S NA	ME (First, Middle, Maiden		CLUI	<u></u>		
Ш	Chauncey B.	Lerkins			Estelle			cling			
0	19a. INFORMANT'S NAME (Type/Print)		196. MAILING AD	DRESS (Street a		Route Number, City or Tox					
욘	Richard Imus (Nep	hew)	11103 9	Stillwa	ter Rd,	Kensingtor	n, MD	20	895		
	20a. METHOD OF DISPOSITION 1	20b.	PLACE ANO DATE OF D	ISPOSITION (Na	me of	OATE 20c. LC	CATION -	City or To	wn, State		
	4 Donation 5 Other (Specify)	Cente	etery, cremetory or other Suburban	Cremato	ry		lver	Spri	ng, MD		
	21. SHOW TURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD 20910										
	Dillo 13.	Chl	M00827	933 (	Gist Ave.	Silver S	princ	, MD	20910		
	3. PABT I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate										
	shock, or heert feliure. List only one cause on each line.  IMMEDIATE CAUSE (Final  Onset and Death										
	disease or condition resulting in death) s.	meto	ustatic	140	ic car	rinor	ne	-	5 month		
		DUE TO (OR AS A	CONSEQUENCE OF):								
NO	Sequentially list conditions, b.	DUE TO (OR AS A	CONSEQUENCE OF):	(							
AT	If any, leading to immediate cause. Enter UNDERLYING	002 10 (011 HD H	consequence or j.								
트	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):								
CERTIFICATION	resulting in death) LAST										
	PART II. Other significant conditions	contributing to deeth by	ut not resulting in t	he underlying	cause given in	Part I. 24s. WAS AN	AUTOPSY	24h	WERE AUTOPSY FINDINGS		
8				andonymą	out of the little	PERFO	RMED?	240	AMAILABLE PRIOR TO COMPLETION OF CAUSE		
						1 TYES :	2 LX NO		OF DEATH?		
≥						_			1 TYES 2 NO		
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL			26. PL	ACE OF DEATH (Ch	ack only one)					
Sic		HOSPITAL: 1 🗀 Inpetient 2 🗀 ER/Outpe		THER:  Nursing Hom	5 Residence	8 Other (Specify)			1.10		
主	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME O	F 28c. INJ		28d. OESCRIBE HOW	INJURY OC	CUREO			
ВУ	1 Natural 5 Pending 2 Accident Investigation	(morally bay, roul)			ES 2 NO						
	3 Suicide 8 Could not be	28a. PLACE OF INJURY building, atc. (Speci	— At home, farm, stree	et, factory, office		281. LOCATION (Street City or Town, State		r or Rural F	Route Number,		
COMPLETED	4 Homicide determined										
7		AN: To the best of my knowle									
Š	one) 2 MEDICAL EXAMINER:	On the basis of examination	and/or investigation, i	n my opinion, d	eath occured at the	time, data and place, as	nd due to ti	he cause(a	) and manner as stated.		
BE (	296. SIGNATURE AND TITLE OF CERTIFIED	110.			29c. LICENSE NUI	ABER	29d. DAT	E SIGNED	(Month, Day, Year)		
TO B	1 von	JULIU	0		1159	441	<b>N</b>	March	1 19, 1993		
	30. NAME AND ADDRESS OF PERSON WHO				Ave #30	20, Langle	v Par	rk. M	D 20783		
	Mona Ellis, M.D.  31. DATE FILED (Month, Day, Year)	32. PEGISTRAB'S SIGNA	ATURE_	hourt	, MAC IF JZ	o, Lungie	,	, "	20,00		
	MAR 22 '93	gina Davidson	And and all								



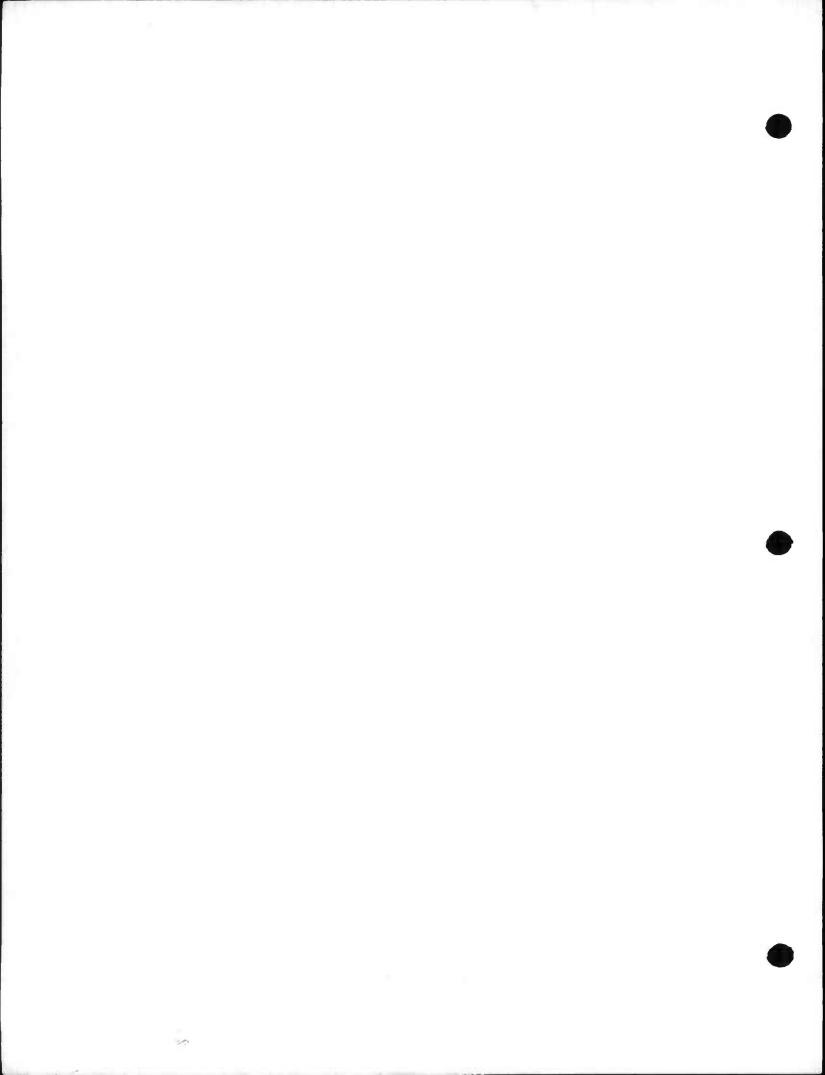
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O NOISINIO	On ATTENDING DUNCIONAL The law consists that the death cartificate he executed within the same offer
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	FOR 1 - STATE REGISTRAR	STATE OF MARY				HEALTH AND DEATH	MENTA	L HYGIEN		, 0	3100
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE	OF DEATN	DAY	YEAR 3.	TIME OF DEATH
- 8	Rose A. Lynch						Mar	h 13,	1993		3:30 A.
	4. SOCIAL SECURITY NUMBER	1	(In yrs. last birthde	y) IF UND	DER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	(Mont	OF BIRTH h, Day, Year)		Country)	ACE (State or Foreign
	150-05-8157	1□M2\xF 8	2 YRS					27,	1910 1		
١	9a. FACILITY NAME (If not institution, give					OR LOCATION OF D	EATH			TY OF DEAT	
	Fernwood Nursing				hesd				Mont		
DIRE	10a. STATE 10b. COUNT		3.4525		N OR LOCA						Dd. INSIDE CITY LIMITS?
	Maryland Mont	gomery	G	altne	ersbu	rg f. ZIP CODE			100 CITIZI		T COUNTRY?
٤	10026 Stedwick R	oad Ant #20	2			0879			U.S.		
FUNEHAL	11. MARITAL STATUS	12 WAS DECEDENT EVER	IN II S ADMED	1	3. WAS DEC	CENDENT OF HISPA				14. RACE -	- American Indian,
	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES	DATES			B 2 NO Spec		Rican, etc.)		Specify:	White
3	15. DECEDENT'S EDU (Specify only highest grad		16a. DECEDENT	of work dor	ne durina mo	ON ost of working	168	KIND OF BU	JSINESS/INDU	ISTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille. Do NO	" use retired	1.)	TOP TOP	_	1			
		2	Teach	er				ducati			
COMPL	17. FATHER'S NAME (First, Middle, Lest)					18. MOTHER'S N			n Surname)		
8	Eugene Razzetti  19a. INFORMANT'S NAME (Typo/Print)		10b MA**	NG ADDR	FRR /Steam	Anna Ba			am Chata 7th 4	Code1	
2	Sharon L. Menake	r				idge Pla					20879
	20a. METHOD OF DISPOSITION		0b. PLACE AND O				OAT		OCATION — C	*	
	1 N Burial 2 Cremation 3 Ren 4 Donation 5 Other (Specify)	noval from State	adonna	ory or othe	er place)		3/				e N.J.
	21. SIGNATURE OF FUNERAL SERVICE L			2	2. NAME A	ND ADDRESS OF F	ACILITY				
1	13.5.4	10				1 Funera			at to be a second	_ L	MD 2007
T	23. PART I. Enter the diseases, or	complications that cause	ed the death. D								Approximate
	shock, or heart fellure. IMMEDIATE CAUSE (Fine)	Liat only one ceuse on	eech line.								Onset and Desti
	disease or condition resulting in death)	. Chronic Re	nal Fai								4 years
	_	Atheroscle		: OF J.							20
<u>i</u>	Sequentially list conditions, if any, leading to immediate		A CONSEQUENCE	OF):							20 years
	cause. Enter UNDERLYING CAUSE (Disease or Injury	c									
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE	OF):							
Į.	resulting in death) LAST	d									
1	PART ii. Other significant condition	ns contributing to death	but not resulting	ng in the	underlyin	ng ceuse given i	n Part i.	24a, WAS A	N AUTOPSY ORMED?		ERE AUTOPSY FINDINGS
3								1 TYES		C	MAILABLE PRIOR TO OMPLETION DF CAUSE OF DEATH?
MEDIC									**		YES 2 NO
2											
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		ОТН		PLACE OF OEATN (C	check only o	ne)			
5	1 TYES 2 X NO	1   Inpatient 2   ER/Ou		4 (X)	Nursing Hor	me 6 - Residence	7				
	27. MANNER OF DEATN  1 X Natural 5 Pending	26a. DATE OF INJURY (Month, Day, Year)	26b.	TIME OF		JURY AT ORK?	28d. DE	SCRIBE HOW	INJURY OCC	URED	
5	2 Accident Investigation	28e. PLACE OF INJUI	DV At home for			YES 2 NO	201.10	PATION (Dune	t and Number o	na Promi Par	de Montes
ם נו	3 Suicide 6 Could not be 4 Homicide detarmined	building, etc. (S)	pecify)	,	ractory, orn		City	or Town, Stat	e)	or noral not	NU NUINOSI,
COMPLE	(Original original or	SICIAN: To the best of my kind	owledge, death occ	curred at 1h	ne 1ime, det	a and place, and du	s to the ca	ruse(s) and m	anner aa state	ıd.	
5	one) 2 MEDICAL EXAMIN	IER: On the basis of examinat	ion and/or investig	stion, in m	ny opinion,	death occured at th	e time, dat	a and place, i	and due to the	cause(a) s	and manner as stated.
BEC	29b. SIGNATURE AND TITLE OF CERTIFIC	ER U.		-		29c. LICENSE N			29d. DATE	SIGNED (A	Aonth, Day, Year)
	- (Hee	My				D206	74		M	larch	16, 1993
	30. NAME AND ADDRESS OF PERSON W										
	Stephen Hellman, 31. DATE FILED (Morith, Dey, Vedir)	M.D. 6240 Mg	ontrose	Road	Rocl	kville,	Mary]	and 2	0852		
	MAR 19 '93	Julia Bavid	10 m	0.0							
-6		- Incomplete	don-himitors	مانع							



STATE	0F	MARYLAND	/ DEPARTMENT	OF I	HEALTH	AND	MENTAL	HYG	IENE
		C	ERTIFICATE	OF	DEAT	ГН		REG.	NO.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI	MENT OF H	EALTH AND ME	NTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)					DATE OF DEATH		3. TIME OF DEATH
	EMIL A. LO	EHI.				MONTH DA		R
	4. SOCIAL SECURITY NUMBER		(In yrs. lest birthday)	F UNDER 1 YEAR	IF UNDER 24 HRS. 7.	RCH 16.	1993	P M PTHPLACE (State or Foreign
	577-03-4809	1 X M 2 D F 8	Q YRS.	ONTHS DAYS		(Month, Day, Year)	C	ountry)
	9a. FACILITY NAME (If not institution, give stre			b. CITY, TOWN C	OR LOCATION OF DEATH	UG.17,19	9c. COUNTY C	SHINGTON D.C.
NO.	BETHESDA RETIREME	NT & NURSIN			THESDA	,		
DIRECTOR	RESIDENCE OF DECEDENT	TI G NORDIN					MONT	GOMERY
R	10a, STATE 10b, COUNTY		10c. CITY, 1	OWN OR LOCAT	TON			10d. INSIDE CITY LIMITS?
		NTGOMERY	SI	LVER S	PRING			1 - YES 2 - NO
₹AL	10e. STREET AND NUMBER			101	ZIP CODE		10g. CITIZEN (	F WHAT COUNTRY?
FUNERAL	1606 WHITE OAK DR	IVE			20910		USA	
E.	11. MARITAL STATUS  1 Never Merried 2 Merried	12. WAS DECEDENT EVER I FORCES? 1 YES	IN U.S. ARMED	13. WAS DEC	ENDENT OF HISPANIC (	ORIGIN? (Specify Yes	or No- 14. R	ACE — American Indian, lack, White, etc.
ВУ	3X Widowed 4 Divorced	IF YES, GIVE WAR OR D			2 NO Specify:	uarto Hican, etc.)		pecify:
				<u> </u>				ITE
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of	ompleted)	16a. DECEDENT'S US	k done during mo:	ON st of working	16b. KIND OF BUS	SINESS/INDUSTR	Y
Z.	Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT use n					
Ž	17. FATHER'S NAME (First, Middle, Last)		ASSISTANT	SECRE'		ACACIA		SURANCE
					18. MOTHER'S NAME (	First, Middle, Meiden	Sumame)	
BE	EMIL W. LOEHL				EMILY	GOEBEL		
2	19a. INFORMANT'S NAME (Type/Print)				nd Number or Rural Route	Number, City or Town	n, State, Zip Gode	)
-	DOROTHEA L. ZEIS	(SISTER)				ILVER SPI	RING, MD	20910
	20a. METHOD OF DISPOSITION  1 X Burial 2 Cremetion 3 Remov	rai from State cen	b. PLACE AND DATE OF I	nlacel		DATE 20c. LO	CATION — City o	r Town, Stata
	4 Donation 5 Other (Specify)	R(	OCK CRÉEK	<u>CEMETER</u>		3/20 WASI	HINGTON	D.C.
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE	$\gamma$	FRANCI	S J. COLL	TNS FIINE	ONT HOM	E INC
	Manual	allins	4					R.,MD.20901
	23. PART i. Enter the diseases, of co	mplications that cause	d the death. Do not	enter the mod	de of dying, such as	cerdiac or respi	ratory arrest.	Approximate
	shock, or heart fallure. Li iMMEDIATE CAUSE (Finel	st only one cause on e	each ilne.				,	Interval Between Onset and Death
	disease or condition	in a sound tal language						Onset and Death
	resulting in death) a.	THE TO (OR AS	A CONSEQUENCE OF):	njavi	1/000			minutes
z		Corona	acce Aust		DITERL			yeare
2	Sequentially list conditions, if eny, leading to immediate		CONSEQUENCE OF):	7	DISCUL			0
3	cause. Enter UNDERLYING CAUSE (Disease or injury	Diabete	i mel	eiter	4			ueau.
ᆵ	that initiated events		CONSEQUENCE OF):					d
CERTIFICATION	resulting in death) LAST							
	PART II Other elgoliticant conditions							
Ŋ.	PART il. Other significant conditions	contributing to deeth r						
~	N/- la a man al- 1		out not resulting in t	he underlying	ceuse given in Pari	i. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
ō		isease;		he underlying	ceuse given in Pari	PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDI			il	he underlying	couse given in Pari		MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
N: MEDI			il	the underlying	ceuse given in Pari	PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
CIAN: MEDI	AIZHUMENS 1)  Infection  25. WAS CASE REFERRED TO MEDICAL	isease;	Urinor	4 Tra	Ceuse given in Pari	PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
YSICIAN: MEDI	AIZHUMENS 1)  Infection  25. WAS CASE REFERRED TO MEDICAL	isease;	Urmor.	y Tra	et	PERFOR  1  YES 2	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1   YES 2   NO  27. MANNER OF DEATH	POPITAL 2 ER/OUTP  26a. DATE OF INJURY	Destirert 3 DOA 4	26. PL. THER: Nursing Home F 28c. INJU	ACE OF DEATH (Check of 5 - Residence 6 - JRY AT 286	PERFOR  1  YES 2	MED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
3Y PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending	ENVOY (PS) HOSPITALI Minperlant 2 - ER/Outs	Detiant 3 DOA 6	26. PL. TIMER: Nursing Home F 28c. INVI	ACE OF DEATH (Check of 5 - Residence 6 - JRY AT 286	PERFOR  1  YES 2  only one)  Other (Specify)	MED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
B	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation  2 Accident Investigation  3 Suicide 6 Could not be	PATE OF INJURY (Month, Day, Year)  28e. PLACE OF INJURY	petiant 3 DOA 4	26. PL THER: Nursing Home F Y M 1	ACE OF DEATH (Check of 5   Rasidence 6   DRY AT   284 ES 2   NO	PERFOR  1 YES 2  only one)  Other (Specify)  DESCRIBE HOW IN  LOCATION (Street e	MED?  NO  JUHY OCCURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
B	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation	POPITAL  Minpetiant 2 = ER/Outs  (Month, Day, Year)	petiant 3 DOA 4	26. PL THER: Nursing Home F Y M 1	ACE OF DEATH (Check of 5   Rasidence 6   DRY AT   284 ES 2   NO	PERFOR  1 YES 2  Other (Specify)  D. DESCRIBE HOW IN	MED?  NO  JUHY OCCURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
B	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation  3 Suicide 6 Could not be determined	PATE OF INJURY (Month, Day, Year)  28e. PLACE OF INJURY building, etc. (Special	petiant 3 DOA 4	26. PL. TIMER: Nursing Home F	ACE OF DEATH (Check of DEATH (	PERFOR  1 YES 2  Only one)  Other (Specify)  d. DESCRIBE HOW In  City or Yown, State)	MED?  NO  NUMBER OF RUI	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
B	25. WAS CASE REFERRED TO MEDICAL EXAMMER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation  3 Suicide 6 Could not be determined  29a. CERTIFIER (Check only)  1 CERTIFYING PHYSICI.	28e. PLACE OF INJURY building, etc. (Specials)	petiant 3 DOA 4  26b. TIME 0 INJUR  /—At home, farm, stre-	26. PL TIMER: Nursing Home F 28c. INVI M 1	ACE OF DEATH (Check of Street of Check of Street	PERFOR  1 YES 2  Annly one)  Other (Specify)  d. DESCRIBE HOW IN  LOCATION (Street a City or Town, State)	MED?  NO  NUMBY OCCURED  NO Number or Rui	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
COMPLETED BY	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	28e. PLACE OF INJURY building, etc. (Specials)	petiant 3 DOA 4  26b. TIME 0 INJUR  /—At home, farm, stre-	26. PL TIMER: Nursing Home F 28c. INVI M 1	ACE OF DEATH (Check of 5   Residence 6   DRY AT RR? ES 2   NO   28f	PERFOR  1 YES 2  Other (Specify)  d. DESCRIBE HOW IN  LOCATION (Street a City or Yown, State)  ne cause(a) and man, data and place, and	MED?  AJURY OCCURED  and Number or Rui  There as stated.	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
BE COMPLETED BY	25. WAS CASE REFERRED TO MEDICAL EXAMMER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation  3 Suicide 6 Could not be determined  29a. CERTIFIER (Check only)  1 CERTIFYING PHYSICI.	28e. PLACE OF INJURY building, etc. (Specials)	petiant 3 DOA 4  26b. TIME 0 INJUR  /—At home, farm, stre-	26. PL TIMER: Nursing Home F 28c. INVI M 1	ACE OF DEATH (Check of Street of Check of Street	PERFOR  1 YES 2  Other (Specify)  d. DESCRIBE HOW IN  LOCATION (Street a City or Yown, State)  ne cause(a) and man, data and place, and	MED?  AJURY OCCURED  and Number or Rui  There as stated.	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
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BE COMPLETED BY	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	26e. DATE OF INJURY (Month, Day, Year)  28e. PLACE OF INJURY building, etc. (Spec	petient 3 DOA 2 26b. TIME 0 INJUM  7—At home, farm, stre- city)  riedge, death occurred a in and/or investigation, i	26. PL THER: Nursing Home F 28c. INJI WOI 1 1 V pt, factory, office	ACE OF DEATH (Check of 5   Residence 6   DRY AT RR? ES 2   NO   28f	PERFOR  1 YES 2  Other (Specify)  d. DESCRIBE HOW IN  LOCATION (Street a City or Yown, State)  ne cause(a) and man, data and place, and	MED?  AJURY OCCURED  and Number or Rui  There as stated.	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
BE COMPLETED BY	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	26e. DATE OF INJURY (Month, Day, Year)  28e. PLACE OF INJURY building, etc. (Spec	petiant 3 DOA 28b. TIME 0 INJURY  7 — At home, farm, streckly)  riedge, death occurred a in and/or investigation, i	26. PL THER: Nursing Home F 28c. INJI WOI 1 1 V pt, factory, office	ACE OF DEATH (Check of 5   Residence 6   DRY AT RR? ES 2   NO   28f	PERFOR  1 YES 2  Other (Specify)  d. DESCRIBE HOW IN  LOCATION (Street a City or Yown, State)  ne cause(a) and man, data and place, and	MED?  AJURY OCCURED  and Number or Rui  There as stated.	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO

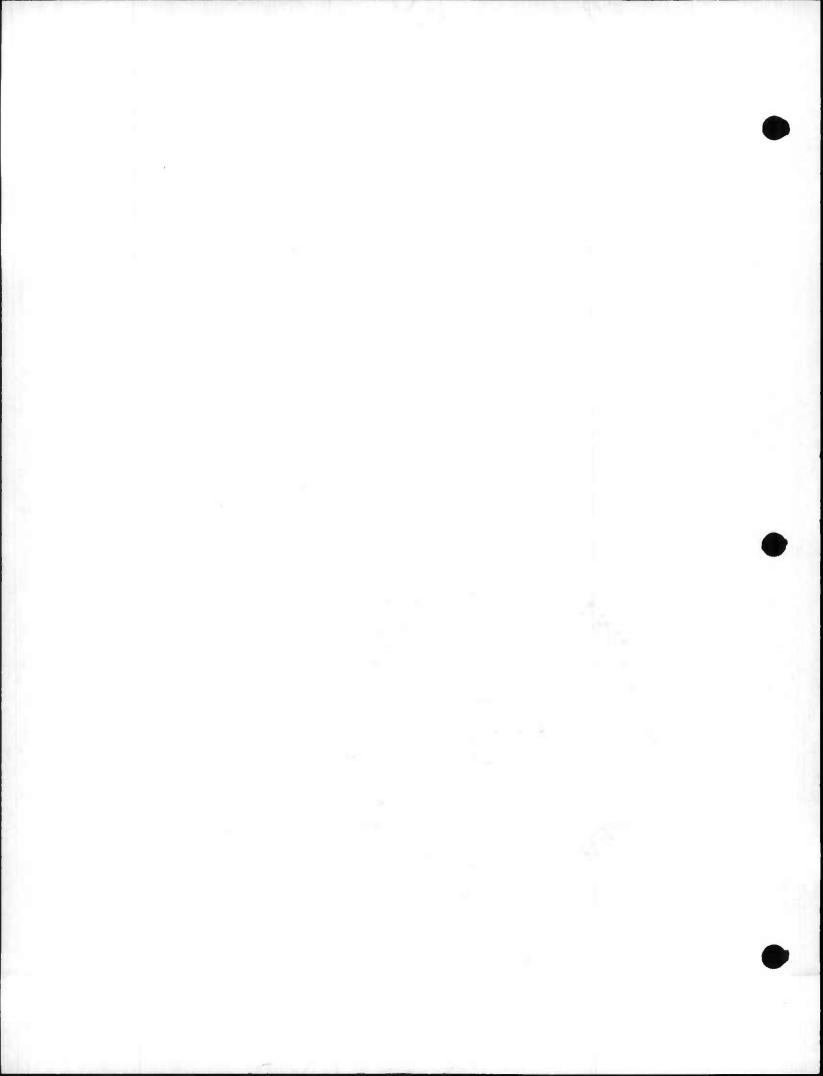


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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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IN THE MOIN ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending	D THE CORP. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the	In a millin 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	MPDRIANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR STATE REGISTRAR	STATE OF MARYL		MENT OF H		MENTAL HYGIE			0 5 7 0 12	
3	1. DECEDENT'S NAME (First, Middle, Last)	Ho N. Le				2. DATE OF DEATH	DAY	YEAR	D. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR		03_	16	93	12:40PM M	
	213-29-0436 1 🗵 M 2 🗆 F 62 YRS. MONTHS DAYS HOURS MIN. (Month, Day, 16.							ser) Country)		
_	Se. FACILITY NAME (If not institution, give stre				R LOCATION OF D	EATH		TY OF DEA		
DIRECTOR	PRINCE GEORGE'S HO	/ERLY		PRIN	CE GE	ORGE				
IRE	10m. STATE 10b. COUNTY Maryland Prince	e George	TON	-			Od. INSIDE CITY LIMITS?			
	10e. STREET AND NUMBER	e deorge	CII	everly	ZIP CODE				YES 2 ND	
FUNERAL	3018 Park Way			101	20785			etnan	AT COUNTRY?	
5	11. MARITAL STATUS	12. WAS DECEDENT EVER I	N U.S. ARMED			NIC ORIGIN? (Specify		14. RACE -	- American Indian	
BY F	1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES			city Cuban, Mexica 2 X NO Specif	y:	- 1		White, etc. Asian	
							1		nstan	
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION completed)	16a. DECEDENT'S I	ork done during mo		16b. KIND OF E	USINESS/INDU	JSTRY		
12	Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT use			Ph.	vm o arr		3	
N N	17. FATHER'S NAME (First, Middle, Last)	4	Pharmac.	ist Assi			rmacy			
	Hien Le					ME (First, Middle, Melde La Ho	n Sumame)			
띪	19a. INFORMANT'S NAME (Type/Print)		105 14411 1910	DDDEED (Om-1)		Route Number, City or T				
임	Huong Le					rly, Maryl				
1	20a. METHOD OF DISPOSITION	200	PLACE AND DATEO				OCATION — C	20785		
	1 Burial 2 Cremation 3 Remon	COU	ntgomery	er Diacel		1	hesda			
	21. SIGNATURE OF FUNERAL SERVICE LICE		negomery	-22. NAME AN	D ADDRESS OF FA	quiry _	nesua,	Mal	yrand	
	Raly for	nah	M00198	Bet 7557 W	: A. Pump :hesda-Cl /isconsir	chrey Functions	ral Ho , Inc.	ome/	0814-3501	
	23. PART I. Enter the diseases, Dr CD	omplications that ceuse	the death. Do no	ot enter tha mo	da of dying, suc	h as cardiec or res	piratory erre	at,	Approximate interval Between	
_		HI I Do . A a . A a								
CERTIFICATION	Sequentially list conditions, If any, leading to immediata		CONSEDUENCE OF	:						
일	CAUSE (Disease or injury	DHE TO OR AS	CONSEDUENCE OF							
Ē	that initiated events resulting in death) LAST	DOE TO (DIT AS )	CONSEDUENCE OF	•					i I	
🗒	d.									
¥	PART II. Other algnificant conditions	contributing to death b	out not resulting in	the underlying	g cause given in		N AUTOPSY DRMED?		ERE AUTOPSY FINDINGS	
음	-					1 _ YES			OMPLETION OF CAUSE OF DEATH?	
MEDIC								1	YES 2 NO	
z										
PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PL OTHER:	ACE OF DEATH (Ch	eck only one)				
YS.	1 VES 2 NO	1 Inpatient 2 - ER/Out	ontient 3 DOA	4 🗌 Nursing Hom		6 Cher (Specify)				
F	27. MANNER OF DEATH  1 Natural 5 Pending	(Month, Day, Year)	26b. TIME	RY WO	RK?	28d. DEŞCRIBE HOV	INJURY OCCI	URED		
B	2 Accident Investigation				res 2 ND					
E	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spe	At home, ferm, st	reet, factory, office		28f. LOCATION (Stree City or Town, Sta	t end Number ( b)	or Rural Roo	ite Number,	
COMPLET	290. CERTIFIER 1 CERTIFYING PHYSIC	IAN: To the best of my know	ledge death occurre	at the time date	and alone and due			7		
N N		: Dn the basis of exemination							and manner se stated	
	29b. SIGNATURE AND TITLE OF CERTIFIER			,						
B	-XIII UI	Allondo	10		29c. LICENSE NUI	WBER (/	29d. DATE	SIGNED (A	forth, Day, Year)	
일	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type,	Print)	UNOV	4	1 5	118	40	
	TSURY M	D. 6005	5 LAN	DOVER	ROAD	46 CI	EVER	LY	20789	
	31. DATE FILED (Month, Day, Year) MAR 22 93	32 MEGISTHAR'S SIGN	ATURE							



93 09733

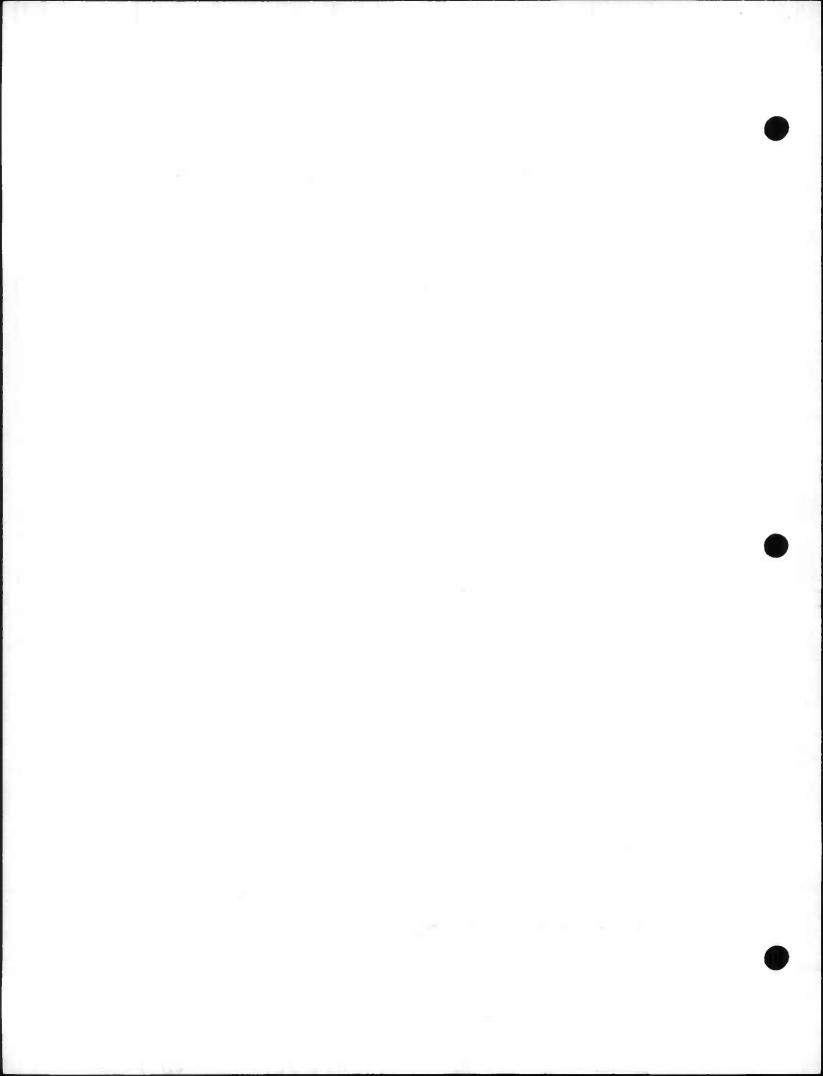
		1 - STATE REGISTRAR	SIAIE UF M		/ DEPAI ERTIF					MENTAL	REG. NO.	E		
		1. DECEDENT'S NAME (First, Middle, I	ast)				- 01	DEA			OF DEATN		3	. TIME OF DEATH
		SUSAN D. LOVE	LAND							MARC	H 18.	1993	YEAR	5:48 P M
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. ).		IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE O	OF BIRTH		. BIRTNPL.	ACE (State or Foreign
plu		213-44-7454	1 🗆 M 2XXF	48	YRS.						MAER 944R			NGTON D.C.
3 should	œ	9a. FACILITY NAME (If not institution,						RE (		ATH		9c. COUNT	Y OF DEAT	
1, 2,	CTOR	THE JOHNS HOPKI	NS HOSPITA	1		DAL	TIME	JIL C	,111			DALI	THUR	C
sages	DIRE	10a. STATE 10b. CO			10c. CIT	Y, TOWN O	OR LOCAT	ION					10	INSIDE CITY
permit. Pages		MARYLAND  10e. STREET AND NUMBER	HOWARD					WOOD						☐ YES 2XXNO
	RA	2252 DAISY	ROAD				101	ZIP CODI	217	0.7		10g. CITIZEN OF WHAT COUNTRY?		
020 physician. burial-transit	FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT	T EVER IN U.Ş. A	RMED	13. 1	WAS DEC	ENGENT C			(Specify Yea			STATES  American Indian,
215-0020 attending physician. se as the burial-tran	ВУ F	1 Never Married 2 Nerried 3 Widowed 4 Divorced	FORCES? 1 IF YES, GIVE W	YES 2XX	ŽNO	- 4	if yea, spe	city Cuba 2 NO	n, Mexica	n, Puerto R	ican, etc.)			Vhite, etc.
15-0 tending as the	ED B	15. DECEDENT'S	EDUCATION	140.5	20000011110									WHITE
2121 al or atte		(Specify only highest			DECEDENT'S (Give kind of life. Do NOT u	work done o	during mo	st of workin	g	166.	KIND OF BUS	INESS/INDUS	TRY	
ND 21 hospital or ached for u		cionerius, coccident y (o-12)	2	·	REGIS	TEREL	NUI	RSE			HEA	LTH CA	ARE	
AN the hos detach	COMPL	17. FATNER'S NAME (First, Middle, Last	i)					18, MOTE	VER'S NAI	ME (First, M	iddle, Malden			
RYL ed by the	BE		R J. DICK		_						WILKE			
MA retain 5 sho	2	19a. INFORMANT'S NAME (Type/Print)  LAWRENCE E.		1							er, City or Town			
may be or, page				20h BLACE	FAMDDATE	05 010000	ITION (NA				MARY:	LAND 2		
ALTIMORE, leath. Page 6 may be funeral director, page xaminer must be		20a. METHOD OF DISPOSITION 1	Removal from State	cemetery, c	remetory or of TGOME	ther place)	MARC	TH 2/	1, 19	993				ARYLAND
ALTIMO death. Page 6 in funeral director.	į	21. SIGNATURE OF FUNERAL SERVICE	E LICENSEE			22 1	NAME AN	D ADDRES	SE OF EA	CHITY				RYLAND
		Menny 2	Zentet	мо	00335	BE	THE	DA-C	HEV	Y CHA	FUNE SE, II	NC. 75	57 W	VISCONSIN
C 12 at		23. PART I. Enter the diseases,	or complications that	caused the d	deeth. Do	not enter	the mo	de of dyl	ng, suci	h es cerdi	ec or respi	ratory arres	t,	Approximats
24 hours on, or red		IMMEDIATE CAUSE (Final												Interval Between Onset and Death
hin hin tely matti	1	disease or condition resulting in death)	· Hemori	rhagic	Sho	ck_								Ihr.
N 8 6 4 8	,	disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events  Due to (or as a consequence of):  Cause (Disease or injury that initiated events)  Due to (or as a consequence of):  Due to (or as a consequence of):  Consequence of):  Due to (or as a consequence of):										10.		
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Q 5 5 5 5	Ë	that initiated events resulting in death) LAST	\D		EQUENCE O		114	14-	hhi	) "		()		7
OS, P. ne death of the attend Mental Hy njury, or	빙		0				(0		14470					3 grs.
1 2 a a a	CAL	PART ii. Other eignificant cond	itions contributing to	deeth but not	reaufting	in the un	darlying	cause g	iven in	Part I.	24a, WAS AN PERFOR		AM	ERE AUTOPSY FINDINGS MILABLE PRIOR TO
O = B = 6	MEDI									-	YES 2	□ NO		OMPLETION OF CAUSE F DEATH?
RECC v requires been signe x. of Healt													1 (	TYES 2 NO
AL has	SICIAN	25. WAS CASE REFERRED TO MEDICA	IL				28. PL	ACE OF DI	EATN (Che	eck only one	)			
F VITAL SICIAN: The law certificate has the State Dep	Sign	EXAMINER?	HOSPITAL:	ER/Outpatient	3 🗆 DOA	OTHER		5 🗌 Re	sidence	8 D Other	(Specify)			
L 일 등투 다	PH	27. MANNER OF DEATN Natural 5 Pending	28a. OATE OF ( (Mgnth, Da	INJURY IV Year!	286. TIM	E OF IURY	28c. INJI	JRY AT	, 1	28d. DE\$0	CRIBE NOW IN	JURY OCCUP	1EO	
ON OING PHYS After this death with	B	2 Accident investigat	-			М			(40					
VISION WITENDING HEITON After The after death The after death The after death The after death The after death	ED	3 Suicide 6 Could not 4 Nomicide determine	building, e	FINJURY At h etc. (Specify)	ome, ferm,	street, facto	ory, office				TION (Street a Town, State)	nd Number or	Rural Routi	e Number,
200	9	29a. CERTIFIER 1 CERTIFYING P	NVSICIAN: To the best of	- kanadada	1-01	4 -4 45 - 41	- 1.			- 2				
76	COMPL		NYSICIAN: To the best of eximiner: On the basis of exi											nd manner as stated.
CENT.	E C	296. SIGNATURE AND TITLE OF CERT							NSE NUM					orith, Day, Year)
D D S M	8	Chrita	· lai					L31	60		14775	_	6/17	
UPSA FEBRUAR	5	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUS	E OF DEATH (IT	EM 27) (Type		0.4	-1	- 10					. 0
		31. DATE FILED (Month, Day, Year)	J HH	R'S, SIGNATURE	N	W of	yfe?	>t.,	B	alto.	mD c	2128	/ <u>.                                    </u>	
	1	MAR 22 93	Juna !	Devidson	Bodel	2								

LOVELAND, SUSAN, 1-258-65-47

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BALTIMORE, MARYLAND 21215-0020

	REGISTRAR		CERTIFI	CATE OF	DEATH	REG. NO	O.	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
12	000 -12 120	J.	ohn Franci	is Lyons	3	MONTH 3 - /	W - 9.	3 5:05 P M
	4. SOCIAL SECURITY HUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER t YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (State or Foreign
		1 M 2 □ F 8	8 yrs.	MONTHS DAYS	HOURS MIN.	June 18,	Washington, DC	
_	6a. FACILITY NAME (If not institution, give stre				OR LOCATION OF DE	ATH	9c. COUNT	Y OF DEATH
D	Shady Grove Advent	:1st Hospita	aT	Rocky	ille		Mon	itgomery
E C	10e. STATE 10b. CDUNTY			10d, INSIDE CITY				
DIRECTOR	Maryland Montg	Jomery	Ro	ckville				LIMITS?
AL	10e. STREET AND NUMBER			101	. ZIP CODE		10g. CITIZE	EN OF WHAT COUNTRY?
FUNERAL	15305 Narcissus W	lay			20853		Unit	ed States
5		12. WAS DECEDENT EVER   FORCES? 1 YES		13. WAS DEC	ENDENT OF HISPAN	IC ORIGIN? (Specify Vin, Puerto Rican, etc.)	es or No- 1	4. RACE — American Indian, Black, White, etc.
ВУ	1 Never Married 2 Married 3 Wildowed 4 Divorced		Specify: White					
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of		16a. DECEDENT'S U	ISUAL OCCUPATIO	ON st of working	16b. KINO OF BI	USINESS/INDU	STRY
9	Elementary/Secondary (0-12)	Coffege (1-4 or 5+)	1	ork done during mo retired.)	or or working		_	
₽ P	12		Clerk/S	sales			y Comp	any
	17. FATHER'S NAME (First, Middle, Last)  Michael M. Lyo	ons				WE (First, Middle, Maide ret O'Kee		
BE	19a. IHFORMANT'S HAME (Type/Print)		19b MAILING	LOORESS /Street o		Coute Number, City or To		Parial
임	Edward M. Flahert	y				Rockville		
	20a. METHOD OF DISPOSITION 1  Burlal 2  Cremation 3 Remov	20	b. PLACE AND DATE DI	F DISPOSITION (Na	me of 3 / 20 / 9	-		
- 8	4 Donation 5 State (Specify) Ent	ombment G	metery, crematory or oth ate of He	<sup>er place)</sup> aven Ma	usoleum	1		ring, Maryland
	21. SIGNATURE OF FUHERAL SERVICE LICE	NSEE	2/00100	Robert	A. Pump	hrev Fune	ral Ho	me/Rockville
	1 aling	toman.	M00198	Rocky	ille, Ma	goméry Av ryland 2	0850-2	805
	23. PART I. Enter the dispuses, or co shock, or heart fellure. Li	inplications that ceuse ist only one cause on (	ed the death. Do no each line.	ot enter the mo	de of dying, such	se cardlec or rea	piratory srre	st, Approximate Interval Between
1	IMMEDIATE CAUSE (Final disease or condition	5-0-1		- 1 - 1	, 4			Onset and Death
	resulting In death)	SEPSIS DUE TO (OR AS	DEPT	10 24	foch			LDAY
-		DIE	( M x 1/1	<b>'</b> A				1
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (DR AS	A CONSEQUENCE OF					
8	cause. Enter UNDERLYING CAUSE (Disease or Injury							
틸	that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF)	:				
巤	d.							
	PART II. Other algnificent conditions	contributing to deeth	but not resulting in	the underlying	g cause given in	Part I. 24a. WAS A		24b. WERE AUTOPSY FINDINGS
DICAL						PERFO	PRMED?	MAILABLE PRIOR TO COMPLETION OF CAUSE
MEC							7	OF DEATH?
						_		- 4
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			ACE OF DEATH (Che	ck only one)		
YSI	1 XYES 2 HD	1 Inpatient 2 ER/Out		OTHER: 4 - Nursing Hom	e 5 🗆 Residence	6 Other (Specify)		
H	27. MANHER OF DEATH  1 Hetural 5 Pending	28a. DATE DA INJURY (Month, Day, Year)	28b. TIME INJU		URY AT	28d. DESCRIBE HOW	INJURY OCCU	PRED
B	2 Accident Investigation				res 2 HO			
0	3 Suicide 6 Could not be 4 Homicide determined	26a. PLACE OF IHJUR' building, etc. (Spe	Y — At home, ferm, st ecify)	reet, factory, offic	'	281. LOCATIOH (Street City or Town, State	and Number or e)	r Rural Route Number,
9	29a. CERTIFIER 1 CERTIFYING PHYSICI	IAM. To the best of an in-						
COMPLETED		AH: To the best of my know On the basis of examination						Cause(e) and manner se stated.
ECC	296. SIGNATURE AND TITLE OF CERTIFIER		5		29c. LICEHSE NUM			SIGNED (Mor)th, Day, Year)
m	Vist SAS	1x lel mi	. X.		DAI	968	▶ .3	3-14-93
욘	30. HAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DI	EATH (ITEM 27) (Type, I		701	100	~	
	VICTOR H	. ESCH,	M.D.	107/7	-Stown	me Driv	2 101	sure rul.
	31. DATE FILED (Month, Day, Year) MAR 22 93	32. REGISTRAR'S SIGN	HATURE door Alandalii	2				,



TO THE HIGH OF ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

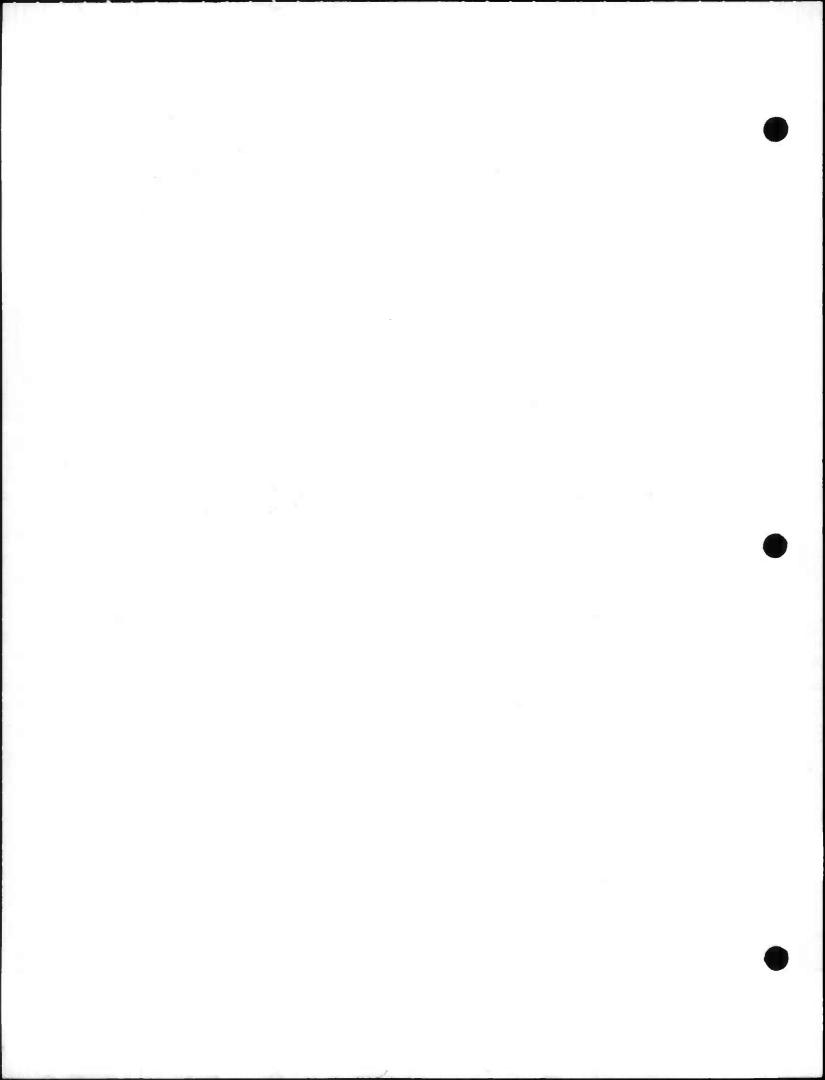
TO THE HIGH CHECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

					OEIIIII	110/11	<u> </u>	DEA		r	EG. NO.				
	1. DECEDENT'S NAME (First, Midd	fle, Last)								2. DATE OF				3. TIME OF DEATH	
	ZENA A. MORTIMER MARCH 23, 1993									5.22 7.44					
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. In												5:23 A M		
	000 14 0400		1   M 2   F			MONTHS		HOURS	MIN.	(Month, Da	y, Year)		Countr		
	089-14-3489		- 1	78	3 143		SEPT. 30, 1914 BRITISH					rish Guiana			
'	9a. FACILITY NAME (If not institution	on, give stre	et and number)			9b. CIT	Y, TOWN	OR LOCATI	ON OF DE	HTA		9c. COU	INTY OF D	EATH	
15	SUBURBAN HOS	PITAI					BETH	ESDA				,	иомто	GOMERY	
15	RESIDENCE OF DECEDE											-	101110	JOHERT	
DIRECTOR	10a. STATE 10b.	COUNTY			10c. C	ITY, TOWN	OR LOCA	TION						10d. INSIDE CITY	
	MARYLAND 1	MONTO	GOMERY			BET	HESD	A						LIMITS?	
ابا	10e. STREET AND NUMBER						10	1. ZIP COO	F			40m CIT	TIZEN OF V	WHAT COUNTRY?	
FUNERAL	5919 RYLAND	DDTII	7				"								
뿔								208					VITEL	STATES	
문	11. MARITAL STATUS  1 Never Married 2 X Marrie		12. WAS DECEDEN FORCES? 1	T EVER IN L	J.S. ARMED 2 NO	13				IIC ORIGIN? (S		or No-	14. RACE Black	E — American Indian, k, White, atc.	
A	3 Widowed 4 Divorced		IF YES, GIVE Y	WAR OR DAT	ES			2 K NO			, 0.00,		Speci	Hy:	
			WORLD	WAR I	1									WHITE	
COMPLETED	15. DECEDEN (Specify only highe	T'S EDUCA	(TION ompleted)	1	(Give kind	'S USUAL (				16b. KIN	D OF BUS	INESS/IN	DUSTRY		
ш	Elementary/Secondary (0-12)		College (1-4 or 5	+)	life. Do NOT	use retired.	)	Pat Or WORK	~						
重			3		REGIST	ERED	NUR	SE			HOS	SPITA	AT.		
0	17. FATHER'S NAME (First, Middle,	Last)						-	HER'S NAI	ME (First, Middl	_				
	ALEXANDER		CAMACHO									,			
	19a. INFORMANT'S NAME (Type/Pri		LAMACHU						LA		ELIDE			AVAILABLE	
임										Route Number, C					
-	FREDERICK T. 1	MORTI	MER		5919	RYLA	ND DI	RIVE,	BET	HESDA	, MAI	RYLAN	VD 2	20817	
	20a. METHOD OF DISPOSITION  1X Burlal 2 Cremation 3	□ Bamou	nt from State		LACE AND DAT			ama of		OATE	20c. LO	CATION -	City or To	wn, Stata	
1	4 Donation 5 Other (Speci		er from State	_ GAT	ery, crematory o	ethar placa EAVEI	V CE	METER	X 3/	26/93	STL	ÆR S	SPRIN	G, MARYLAND	
	21. SIGNATURE OF FUNERAL SER	VICE LICE	NSEE		0831	.22	NAME A	ND ADDRE	SS OF FAC	CILITY	DIL	, Little	71 1(11)	O) THIRTHAND	
	Ka bera a	ms.	m. 00 -	//	nence	R	OBER!	PA.	PUMP	HREY	UNEF	RAL F	IOME/	, MICCONCIN	
	Lacare	1////	west	0,		- A	VENU	E, BE	THES	DA, MA	RYLA	AND	2081	4-3501	
	22. NAME AND ADDRESS OF FACULTY ROBERT A. PUMPHREY FUNERAL HOME/ ROBERT A. PUMPHREY FUNERAL HOME/ BETHESDA-CHEVY CHASE, INC. 7557 WISCONSIN AVENUE, BETHESDA, MARYLAND 20814-3501  23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory erreat,  Approximate														
1 1	anock, or neart tallure. List only one cause on each line.														
	IMMEDIATE CAUSE (Final disease or condition SERTI SINCK														
	resulting in death)														
	DUE TO (OR AS A CONSEQUENCE OF):														
Z	Sequentially list conditions, S. S. S. S. S. S. S. S. S. S. S. S. S.														
CERTIFICATION	If any, leading to immediate		DUE TO	(OR AS A C	ONSEQUENCE	OF):									
8	CAUSE. Enter UNDERLYING													ļ	
III.	CAUSE (Disease or Injury that Initiated events	<b>1</b>	OUE TO	(OR AS A C	ONSEQUENCE	OF):									
듄	resulting in death) LAST	40.0													
빙		a.													
	PART II. Other algnificant co	onditiona	contributing to	death but	not resulting	In the u	nderiyin	g cause g	iven in i	Part I. 24s	. WAS AN		24b.	WERE AUTOPSY FINDINGS	
EDICAL	15to 0	BURTE	H FIR	RUN	COLOS						PERFOR	/		AVAILABLE PRIOR TO COMPLETION OF CAUSE	
입	Al7 Horano	016	Ohea	-						1	YES 2	NO		OF DEATH?	
Σ	NATION P. IV.	177	CD CAO							_				1 TES 2 NO	
z													- 1		
PHYSICIAN:	25. WAS CASE REFERRED TO MED EXAMINER?		HOEDITAL					ACE OF D	EATH (Che	ck only one)					
Š	1 - YES 2 10 NO	1 1	HOSPITAL:	ER/Outpati	lent 3 🗆 DOA	4 Nu		e 5 🗆 Re	sidence	B ☐ Other (Sp	ecffv)				
主	27. MANNER OF DEATH		28a. DATE OF		28b. T	ME OF		URY AT	I	28d. DESCRI		LIURY OC	CURED		
	Natural 5 Pendir		(Month, D	ay, Year)	1	NJURY	WO	PRK?	ا ۵۰۰۰				OUNCO		
BY	Poolderin	Igation	00. 51.105.0	F 101 11 11 11 11 11 11 11 11 11 11 11 11					J NO						
<u>a</u>	3 Suicide a Could 4 Homicide detarm		building,	atc. (Specify,	At homa, farm	, street, fac	tory, offic	•		28f. LOCATIO City or To	N (Street a wn, Stete)	nd Number	r or Rural R	loute Number,	
	TO TO TO TO TO TO TO TO TO TO TO TO TO T								H						
COMPLET	25s. CERTIFIER 1 CERTIFYING	G PHYSICIA	AN: To the best of	my knowled	ige, death occu	rred at the	time, date	end place	and due	to the causes	and man	Der se et-	tied.		
ž														) and menner as stated.	
용				14	· · · · · · · · · · · · · · · · · ·		-prott, 0	vocul		re, usite and	prince, BIN	- GUE 10 (I	cause(8	y and memmer as stated.	
BE	396. SIGNATURE AND TITLE OF CI	ERTIFIER	MI					29c. LICE	NSE NUM	BER		29d. DAT	E SIGNED	(Month, Day, Year)	
			A AM					0-	ns	36		1	3/23	102	
임	30. NAME AND ADDRESS OF PERS	SON WHO	COMPLETEO CAUS	SE OF DEATH	H (ITEM 27) (Ty)	e, Print)	-	^					1 .	- 414	
	CARC I M	ARG	our in	10	MRS	Roci	VIUS	CE V	KE.	Revioli	WE	MC	) 1	0851	
	31. DATE FILED (Month, Day, Year)	,	32. REGISTRA	R'S SIGNATI	URE	4		-	-	000				_	
	MAR 24 0	3	gulia	Davidson	URE	الم									



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BALTIMORE, MARYLAND 21215-0020

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the attending physician Mental Hygiene prior to

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296. SIGNATURE AND JITLE OF CERTIFIER

C DIVISION OF VITAL

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TIME SECONDS, F.O. DOAD	law requires that the death certificate be
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5	that
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2	The same
5	PHYSICIAN: The
	THE ATTENDING PHYSIC
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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MONTH 3 MICHAEL MYRON MRYCZKO 93 1:324 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 087143624 Coupty) 12 M 2 □ F 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH SC. COUNTY OF DEATH Perry Point VA Medical Center DIRECTOR Perry Point, Ma. 21902 Cecil RESIDENCE OF DECEDENT 10c. CITY TOWN OR LOCATION 10d. INSIDE CITY MD. MONTGOMERY ROCKVILLE 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20853 14328 BLACKMON DR. U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 A YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Marri BY 3 Widowed 4 Divorced WWII, KOREA, VIETNAM WHITE COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest Elementary/Secondary (0-12) College (1-4 or 5+) DEALER RET. OFFICER AND STAMP U.S. ARMY 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) METRO MRYCZKO ANNA UNKNOWN 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 VIRGINIA A. MRYCZKO SAME AS 20a. METHOD OF DISPOSITION
1 Burial 2 A Cremation 3 Re 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE CHAMBERS CREMATORY 4 Donation 5 Other (Specify) RIVERDALE. MD. 21. SIGNATURE OF FUNERAL SERVICE LIGERISEE 20910 M00091 W. W. CHAMBERS CO. INC, SILVER SPRING, MD. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition Probable Ischemic Bowel/Obstruction 1 day resulting in death) DUE TO (OR AS A CONSEQUENCE OF): MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS Organic Brain Syndrome MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? Seizure Disorder 1 YES TO NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
12 Inpetient 2 ER/Outpetient 3 DOA OTHER: 1 TES 2 NO 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 6 Could not be determined 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 4 Homicide 

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30. NAME AND ADDRESS OF PERSON WHO COL PLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 31. DATE FILED (Month, Day, 32. REGISTRAR'S SIGNATURE his Davidson Randoll 64 ,03

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

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29d. DATE SIGNED (Month, Day, Year)

funeral director, page 5 should be detached

and completely filled in by the burlal, cremation, or removal.

Hygiene prior to

the attending physician Mental Hygiene prior to

has been signed by t Dept. of Health and

r this certificate hi

DIRECTUR: After the hours after death w

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31. DATE FILED (Month, Day, Year) MAR <4

for use as the burial-transit permit. Pages 1, 2, 3 should

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MISION OF VITAL RECORDS, P.O. BOX 68760	w
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. JACK MAIZE II 2. DATE OF DEATH DAY DOA 500 DON 93 Marze 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 1 M 2 - F YRS. 48 225-70-4358 9-7-1944 PENNSYLVANIA 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 10921 INWOOD AVENUE/420 SILVER SPRING MONTGOMERY 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND MONTGOMERY SILVER SPRING 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 10921 INWOOD AVENUE/420 20902 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO IF YES, GIVE WARTOR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuban, Mexican, Pt 1 TES 2 NO Specify: 1 Never Married 2 Married BY 3 Widowed 4 Divorced CAUCASIAN COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY ntary/Secondary (0-12) College (1-4 or 5+) 12 DOCENT SMITHSONIAN INSTITUTE 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ JACK G MAIZE JOSEPHINE MONCURE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 JACK G MAIZE BOX 93 FROGS MARSH ROAD DRAYDEN CITY, MD 20630 pe 20s. METHOD OF DISPOSITION

1 X Burlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State 1 Burlet 2 Cremetion 3 4 Donation 5 Other (Specify) must IVY HILL CEMETERY 3-25 ALEXANDRIA, VIRGINIA 21. SUBMATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY DEMAINE FUNERAL HOMES, INC ALEXANDRIA, VIRGINIA 22314 medical 23\_PART I. Enter the diseases, or complications that caused the death. De not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition resulting in death) Cardiovas culo Deser event, DUE TO (OR AS A CONSEQUENCE OF): traumatic MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (QR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 Injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS shows any AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 T NO 1 TYES 2 T NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 6 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) marked, 28b. TIME OF 28c. INJURY AT WORK? 28d. DEȘCRIBE HOW INJURY OCCURED Natural 2 Accident 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 00 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED 8 Could not be 4 Homicide 28 TO THE HOSPITAL AT ATT TO THE FUNERAL DIRECTOR DE fined within 72 hours at IMPORTANT IT Item 23 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. COMPL REDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) end manner es stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 46 -23-DOSC 2 30. NAME AND ADDRESS OF RERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

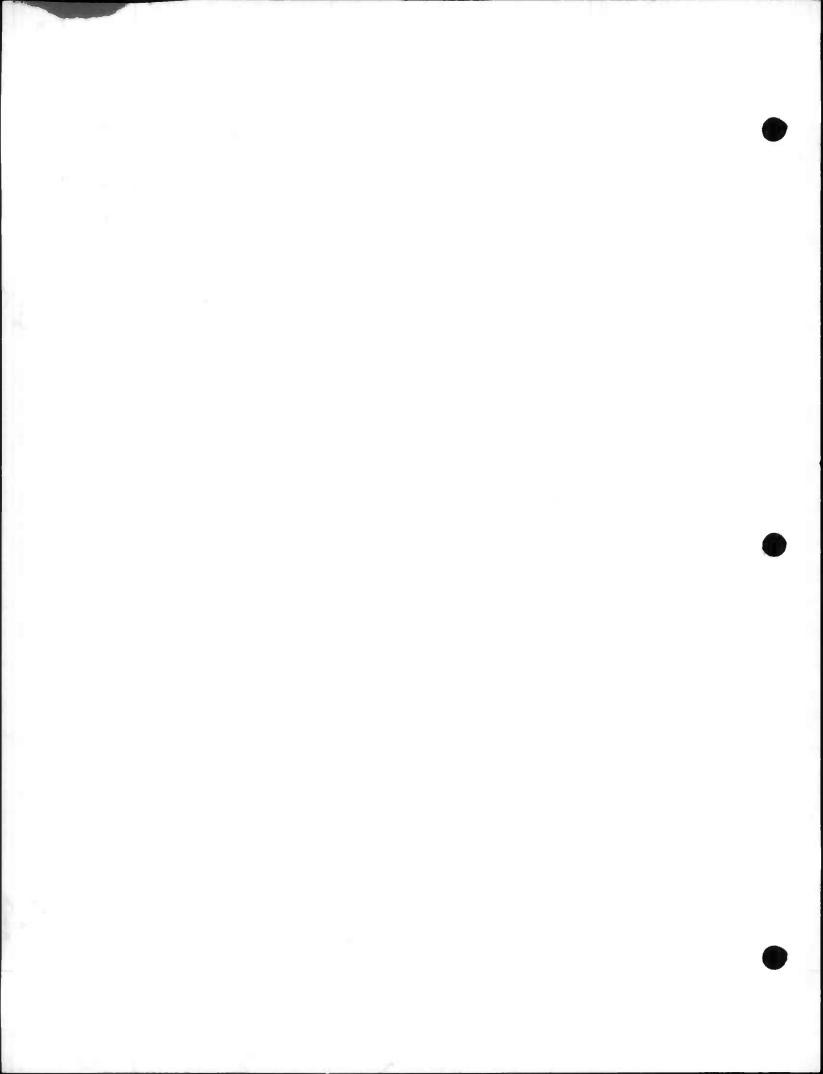
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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MAGNUS ENNIFER 00 50AM 03 22 MBER | SEX | 1 | M 2 | F 6. AGE (In yrs. lest birthday)

63 YRS. 4. SOCIAL SECURITY NUMBER IF UNDER 24 HRS DATE OF BIRTH IF UNDER 1 YEAR 22 HOURS detached for use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH MONTGOMERY DIRECTOR SUBURBAN HOSPITAL BETHESDA RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MONTGOMERY TAKOMA PARK MD 1 YES 2 NO 7310 CEDAR AVE COMPLETED BY FUNERAL 10g. CITIZEN OF WHAT COUNTRY? "Z9012 U.S.A. ifter death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 14. RACE — American Indian, Black. White, atc. 1 Never Merried 2 Merried Widowed 4 Divorced 1 YES 2 NO Specify: WHITE 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY most of working (1-4 or 5+) Elamentary/Secondery (0-12) FEDERAL GOVERNMENT OFFICE EXECUTIVE 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname GLADYS HOLLAND FRANK VERWIEBE funeral director, page 5 should be notified at BE and and Number or Rural Route Number, City or Town, State, Zip Code) 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Stre 5 SAME AS FRANK MAGNUS pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION ? Name of 3/23/93 ALEXANDRIA, VA. must 1 Donation 5 Differ Speed METROPOLITAN CREMATORY examiner 21. SIGNATURE OF FUNEFIAL BEFORCE LICENSEE TAKOMA FUNERAL HOME 254 CARROLL ST N.W. WASHINGTON, D.C. 20012 filled in by the 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, or removal. medical Approximate shock, or heart feilure. List only one ceuse on each Interval Betwe **IMMEDIATE CAUSE (Final** Onset and Death and completely filled burial, cremation, the disease or condition NEPSIS 1 WK event. resulting in death) DUE TO (OR AS A CONSEQUENCE OF): LEFTLEG 2" ARTERIAL THROMBURS traumatic MEDICAL CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate UNCERTAIN ORIGIN ADENOCARCINOMA cause. Enter UNDERLYING CAUSE (Disease or Injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST the attend any injury, PART II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE item 23 shows 1 YES 2 NO PHYSICIAN: has be Dept. 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h **EXAMINER?** HOSPITAL OTHER 1 YES 2 NO 1) Inpatient 2 ER/Outpetient 3 DOA ome 5 - Residence 6 - Other (Specify) 0 27, MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this c is marked. 1 Natural 1 YES 2 NO BY After death Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) OR ATTEND COMPLETED 6 Could not be determined 28 4 Homicide Tem CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) end manner as stated. MPORTANT: 11 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, data end place, end due to the ceuse(e) end menner ee stated. 29b. SIGNATURE AND TITUE OF CERTIFIER BE 29d. DATE SIGNEO (Month, Day, Year) D39283 3-22-93 luson arth 2 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 5401 WESTERN N.W. AUE. WAShington, D.C 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE ,03 whia Davidson 64 Andelle

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

4. SOCIAL SECURITY NUMBER S. SEX 8. AGE (in yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 1 XM 2 | F 10/20/2 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, gir 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Roc hady Gro 10b. COUNTY 10c. CITY, TOWN OR LOCATION MARYLAND MONTGOMERY SILVER SPRING permit. FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE use as the burlal-transit 911 GABLE STREET 20901 retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Mexican, Puerto Rican, etc.) BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 1 TYES 2 NO ВУ 3 Widowed 4 Divorced WWIT COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest gra Hege (1-4 or 5+) in by the funeral director, page 5 should be detached for or removal. Elementary/Secondary (0-12) SALES MANAGER PNEUMATIC once. 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) FRANCIS **MYERS** ELIZABETH Ħ Μ. BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 ISABELL C. MYERS 11 GABLE STREET, SILVER SPRING, MD 20901 pe METHOD OF DISPOSITION
Burtal 2 Cremation 3 Removal from State 24 hours after death. Page 6 may 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must ■ □ Donation 5 □ Other (Specify) PAUL CEMETERY 3/27 examiner 21. BIGNATURE OF FUNERAL SERVICE LICENSEE FRANCIS J. COLLINS FUNERAL HOME, INC. \$00 UNIVERSITY BLVD., W., SIL. SP., MD 20901 medical signed by the attending physician and completely filled in by Health and Mental Hyglene prior to bunal, cremation, or remo 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest, ehock, or heart feiture. Liet only one cause on each line. IMMEDIATE CAUSE (Final the disease or condition resulting in death) within 3 event. DIVISION OF VITAL RECORDS, P.O. BOX 68760, DUE TO (OR AS A CONSEQUENCE OF): executed traumatic CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate requires that the death certificate be cause. Enter UNDERLYING CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 Injury, PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL any 1 YES 2 NO shows 2 has been of h PHYSICIAN: WE 23 25. WAS CASE REFERRED TO MEDICAL DR ATTENDING PHYSICIAN: The I DIRECTOR: After this certificate ha hours after death with the State D. Item : 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 Onpatient 2 - ER/Outpatient 3 - DOA 1 TES 2 200 me 5 🗆 Rasidence 8 🗆 Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked. (Month, Day, Year) 1 Natural 5 Pending В 1 YES 2 NO 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 80 8 Could not be determined COMPLETED 4 Homicide 200 tem 29s. CERTIFIER (Chack only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. PITAL INTERAL I 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 띪 MO 15046 2 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

1926

32. REDISTRAR'S SIGNATURE

MONTGOM VILL AVE

CERTIFICATE OF DEATH

FOR STATE REGISTRAR

F-rancis

STEPHEN

31. DATE FILED (Month, Day, Year)

1. DECEDENT'S NAME (First, Middle, Last)

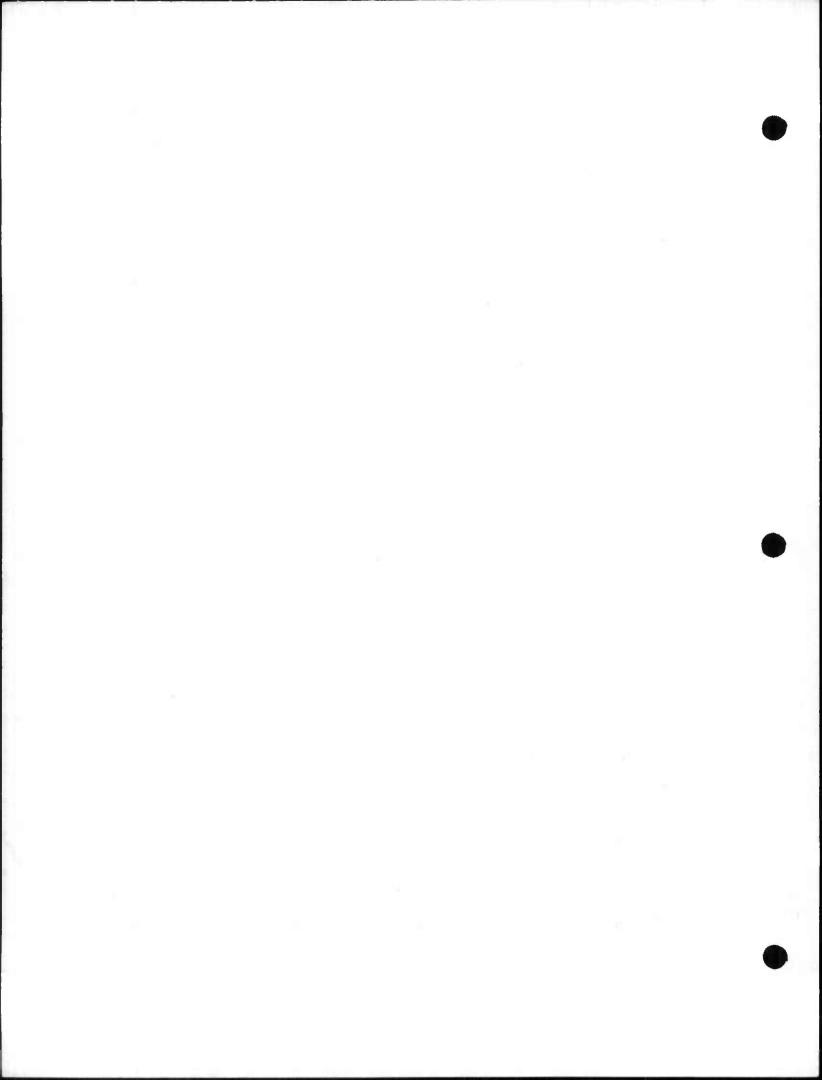
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93 09739 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 2. DATE OF DEATH 3. TIME OF DEATH 0735 M 03-24 8. BIRTHPLACE (State or Foreign PENNSYLVANIA 9c. COUNTY OF DEATH non 10d. INSIDE CITY LIMITS? 1 YES 2 NO 14. RACE — American Indian, Black, White, etc. WHITE 16b. KIND OF BUSINESS/INDUSTRY **FASTENERS** McGOVERN 20c. LOCATION — City or Town, State SPRINGFIELD, PA Approximate Interval Between Onset end Deeth

24b. WERE AUTOPSY FINDINGS WAILABLE PRIOR TO

1 YES 2 NO

COMPLETION OF CAUSE

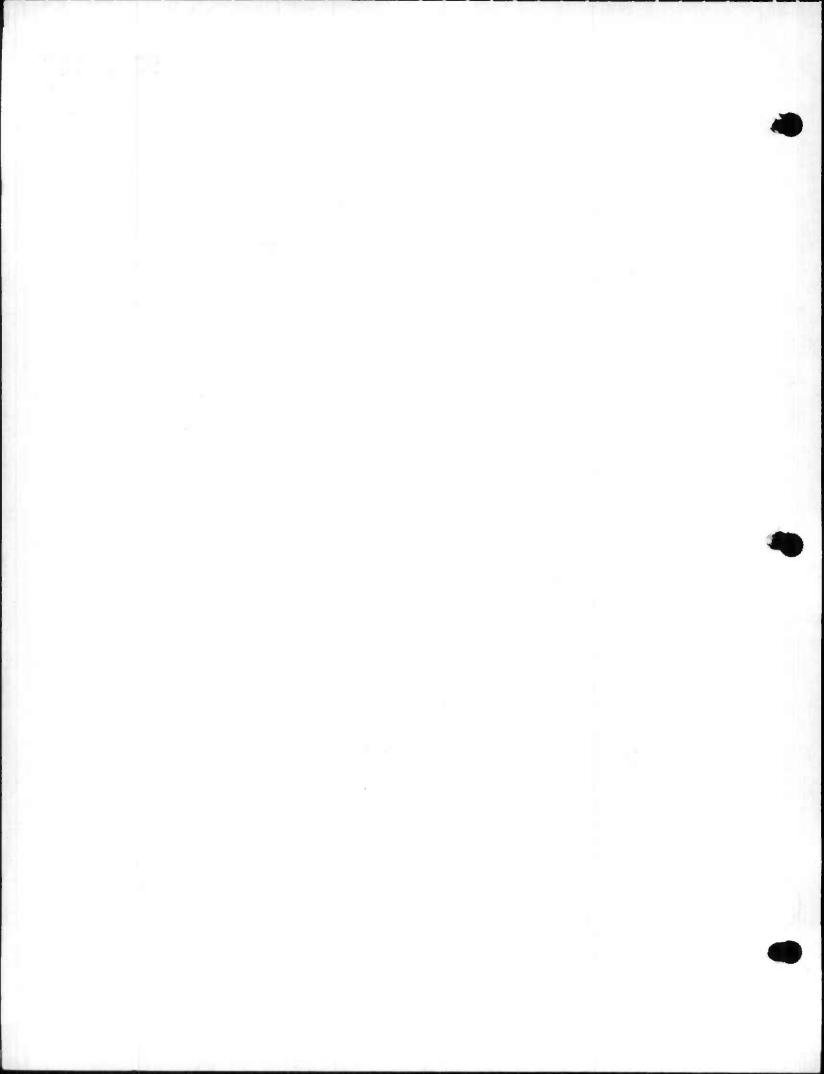


TO BE COMPLETED BY FUNERAL DIRECTOR

	THE HUSPITAL ON ATTENDING PHYSICIAN. The law requires that the death certificate be executed within the Jury after death. Page 6 may be retained by the hos	TO THE PLANE AND THE CONTROL AND THE STATE THE STATE THE STATE OF MENTAL PHONE PRINCIPLE OF THE STATE STATE OF THE STATE O	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	HUSS	RUNE	TAN
	世の	TO ME RUNERAL DIRECTOR After this commission has been signed by the attending physician and completely filled in by the frame of Health and Mental Holene prior to burial, cremation, or removal.	MPOR
4	or pure	SEC. 3	. =

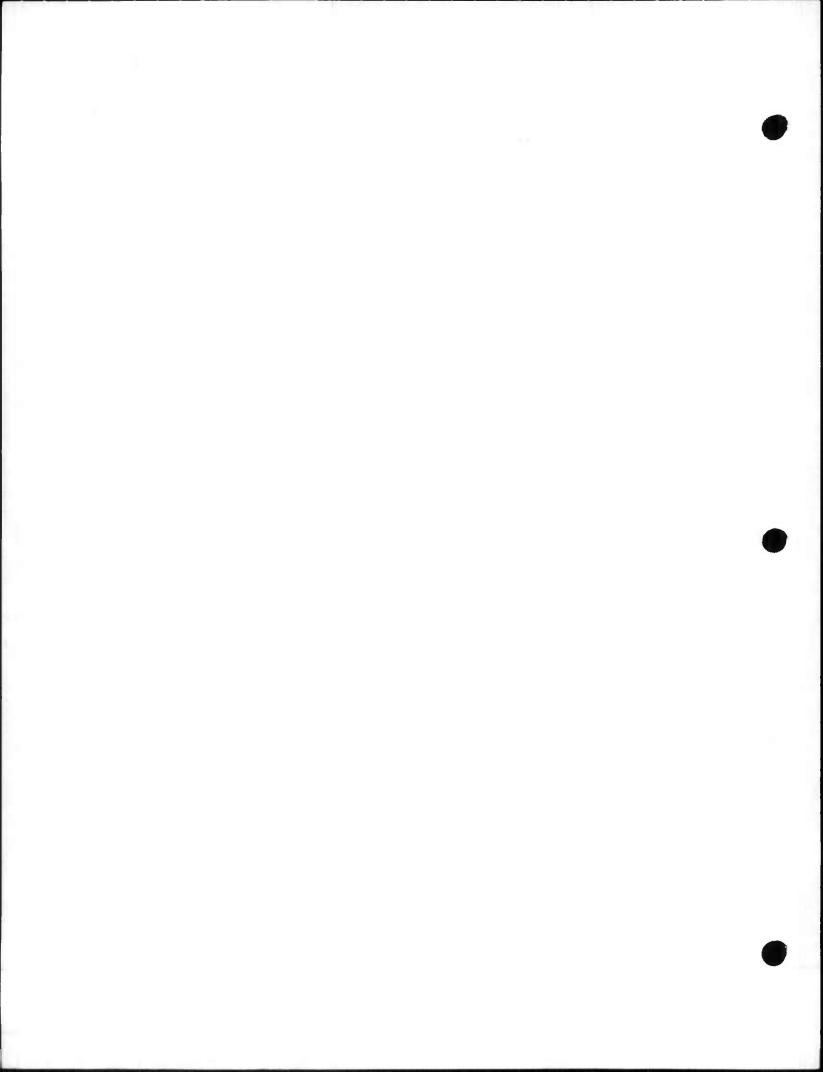
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE REGISTRAR		STATE OF N		D / DEPAR			EALTH AND	MENTA	HYGIEN REG. NO.	E		
1. OECEDENT'S NAME (First,	Middle, Last)							2. DATE	OF OEATH			TIME OF OEATH
MABEL McC	ARDELI							Ma	rch 21		EAR 2	:10 A M
4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In yes	s. last birthday)		ER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH	8.		ICE (State or Foreign
578-20-2717	2	1 🗌 M 2 🟋 F	8	7 YRS.	MONTHS	DAYS	HOURS MIN.		e 15,			ngton, D.C
9s. FACILITY NAME (If not in	stitution, give st	reet end number)			9b. CIT	ry, town o	R LOCATION OF DI	EATH	- 21	9c. COUNTY	OF DEAT	Н
SACRED HEA		1E			H	ATTS	VILLE			PRINC	E GE	ORGE'S
10e. STATE	10b. COUNTY			10c. CIT	Y, TOWN	OR LOCAT	ION				104	d. INSIDE CITY
Maryland	Princ	e George	's	Hv	atts	ville	2				100	YES 2 NO
10e. STREET AND NUMBER			<del>-</del>				ZIP CODE			10g. CITIZEN	OF WHA	T COUNTRY?
5805 Queens	Chape	1 Road					20782			Unite	d St	ates
11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1	T EVER IN U.S	ARMEO	13		ENDENT OF HISPA			or No- 14	RACE - Black, W	American Indian, hite, etc.
1 Never Married 2 3 N Widowed 4 Divo	100	IF YES, GIVE Y					2X NO Specif				Specify: Blac	
15. DEC	EDENT'S EDUC	CATION	164	. DECEDENT'S	USUAL	OCCUPATIO	N .	166	KINO OF BUS	INESS/INDUS		K.
	highest grade			(Give kind of life. Do NOT u	work don	e during mo:	st of working	1				
11	-12)	College (1-4 or 5		eacher	Ass	ista	nt		Privat	e Scho	01	
17. FATHER'S NAME (First, M	iddle, Lest)						16. MOTHER'S NA	AME (First,	Middle, Malden	Surname)		
John Ander	son						Ophe1	ia F	erguso	n		
19e, INFORMANT'S NAME (1	ype/Print)			19b. MAILING	ADDRE	SS (Street a	nd Number or Rural	Route Num	ber, City or Tow	n, State, Zip Co	ode)	
Grace Wilk	tes						Ave. N.		Washin	gton,	D.C.	20011
20e. METHOD OF DISPOSIT		oval from State	oth	ner place)			netery, crematory or			CATION — Cit		
4 Donation 5 Other			_ Ha:	rmony l			Park 3	_	93 Lan	dover,	Mar	yland
21. SIGNATURE OF FUNERA	I SERVICE LIC	ENSEE			2	McGu:	ire Fune	ral	Servic	e, Inc		20012
John.	1 100	Min	2			7400	Georgia	Ave	. N.W.	Wash	ingt	on, D.C.
23. PART I. Enter the d ahock, or h IMMEDIATE CAUSE (Fin	eart fallure.	List only one car	se on each	line.					disc or reep	ratory arrea	it,	Approximate Interval Batween Onset and Daath
disease or condition resulting in death)	<b>→</b>	b all	herald	evetu	he	art	lisees					
		OUE TO	(OR AS A CO	NSEQUENCE C	OF):	0 -						
Sequentially list condit	lons.	a un	estive	Heart	try	len	٤					
If any, leeding to imme cause. Enter UNDERLY	diate	DUE IG	NOH AS A CO	MSECUENCE C	Jr.):							
CAUSE (Disease or Injuthat Initiated events		C. DUE TO	(OR AS A CO	NSEQUENCE (	OF):							-
resulting in death) LAS	ST	4										
		u										
PART II. Other algolification			death but	not reculting	In the	underlyin	g cause given in	Part I.	24a. WAS AN PERFO		Al	ERE AUTOPSY FINDINGS MILABLE PRIOR TO
fence	lenen	un							1 TYES	NO D		F DEATH?
											1	YES 2 NO
25. WAS CASE REFERRED T	n Menical					24 21	ACE OF PEARS	Shaab				
EXAMINER?	O MEDICAL	HOSPITAL:			QTH	EB:	ACE OF DEATH (C					
1 YES 2 2 27. MANNER OF DEATH		1 Inpatient 2		28b. Til	-	1	BURY AT	ν	SCRIBE HOW	INJURY OCCU	RED	
_	Pending		Day, Year)	18	IJURY M	WC	PRK?					
2 Accident 3 Suicide	Investigation	28e. PLACE	OF INJURY	At home, farm,	street, 1	actory, offic	•	28f. LO	CATION (Street	end Number or	Rural Rou	te Number,
4 Homicide	Could not be determined	building	, etc. (Specify)					Ch	or Town, State	)		
29e. CERTIFIER	TIFYING DUVE	ICIAN: To the best of	f my knowled	ne death norm	read at the	e time det	end place and 4	e to the co	use(s) and me	nner as stated		
(Crieck only	1											nd manner ee stated.
29b, SIGNATURE/AND TITL	11/1						29c. LICENSE NI					Ignth, Day, Year)
10, Vh	W/A								C			43
30, NAME AND ADDRESS O	F PERSON W	O COMPLETED CAL	SE OF DEATH	1 (ITEM 27) (Tvc	oe, Print)		000	70		<del></del>	129	1-
Peter MI	his11	MO	75001	Green	مسال	CH.	Or. Gre	Can Ge	It M	0 207	70	
31. DATE FILED (Month, Day	Year)		AR'S SIGNATI		-07							
		80.		Co.								



STATE OF MARYLAND / DEPARTME	INT OF HEALTH AND I	MENTAL HYGIENE
CERTIFICA	TE OF DEATH	REG. NO.

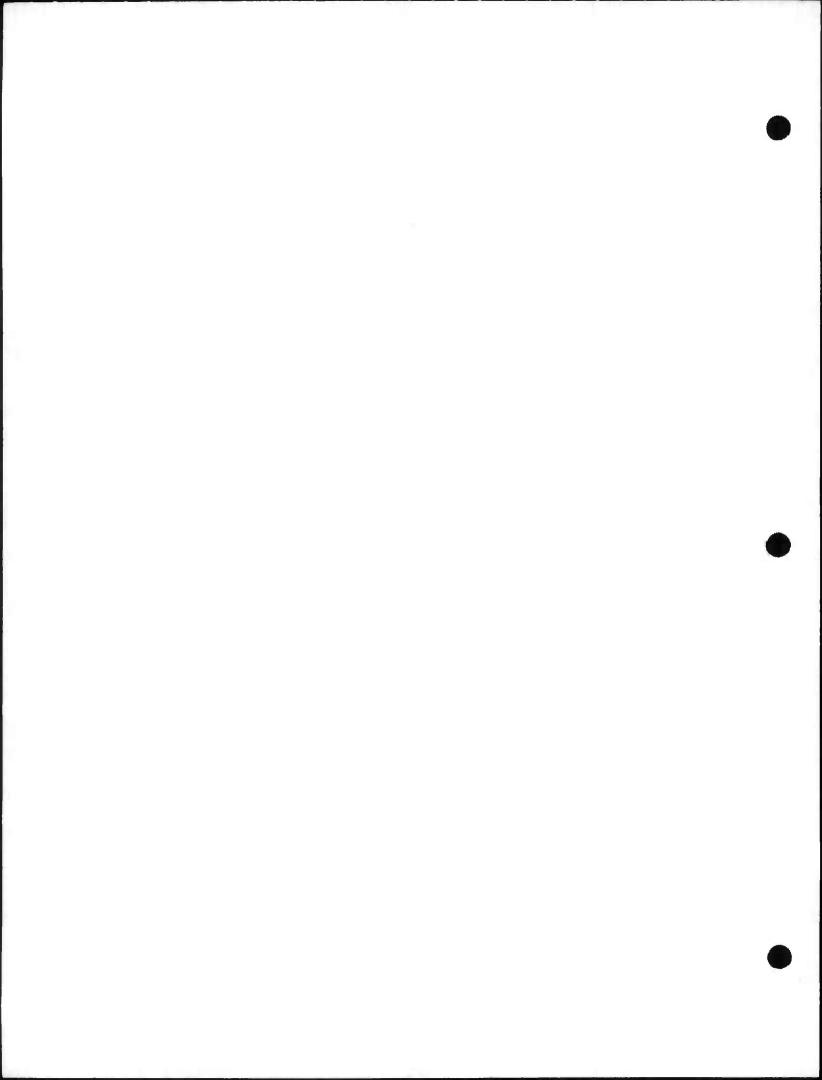
	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC	ENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last)	N.	Mills		2. DATE OF DEATH	B- 93	3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER 578-09-2408	1 4 2 F 7.	8 YRS. MOI	UNDER 1 YEAR IF UNDER 24 HRS. ITHS DAYS HOURS MHI.	7. DATE OF BIRTH (Month, Day, Year) MARCH 4,	Cour	HPLACE (State or Foreign stry) RGINIA			
TOR	9a. FACILITY NAME (If not institution, give str HOLY CROSS HOS RESIDENCE OF DECEDENT	PEATN	9c. COUNTY OF MONTGOI							
DIRECTOR	10a. STATE 10b. COUNTY	TGOMERY		OWN OR LOCATION  ER SPRING		10d. INSIDE CIT LIMITS? 1X7 YES 2				
FUNERAL	106. STREET AND NUMBER 12503 ATHERTON	DRIVE		101. ZIP CODE 2090	06	109. CITIZEN OF WHAT COUNTRY? USA				
BY	11. MARITAL STATUS 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN FORCES? 1 X YES IF YES, GIVE WAR OR DA	2 NO	13. WAS DECENDENT OF HISPA If yea, specify Cuban, Mexic 1 YES 2 NO Speci	NIC ORIGIN? (Specify Year, Puerto Rican, etc.)	s or No- 14. RAG Bla	CE — American Indian, ck, White, etc. city:			
COMPLETED	15. DECEDENT'S EDUC, (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed) College (1-4 or 5+)	16a. DECEDENT'S USU (Give kind of work Ma. Do NOT use red	done during most of working	16b. KIND OF BU	ISINESS/INDUSTRY	WILLE			
OMP	1.2 17. FATHER'S NAME (First, Middle, Lest)		SIGN PAIN		PAINTI					
		MILLS		ELIZABI		NEWTO	NT.			
TO BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADI	DRESS (Street and Number or Rural			N			
F	ELLA MAE MILLS			THERTON DRIVE						
	20e. METHOD OF DISPOSITION  1	val from State Cem	PLACE AND DATE OF DI Hetery, crematory or other I ETROPOLITA	N CREMATORY	3/19 ALE	XANDRIA.				
	21. SIGNATURE OF FUNERAL SERVICE LICE  CLUVUS.	Stynd		22. NAME AND ADDRESS OF F FRANCIS J. COI 500 UNIVERSITY	LLINS FUNE Y BLVD., W	., SIL. S	, INC. SP., MD 20901			
	23. PART I. Enter the diseases, or conshock, or heart fellure. L. IMMEDIATE CAUSE (Final disease or condition resulting in death)	lat only one cause on e	ech line.	enter the mode of dying, sur lost Failur Tertung Di		eliratory srrest,	Approximate interval Between Onset and Death			
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events  DUE TO (OR AS A CONSEQUÊNCE OF):  DUE TO (OR AS A CONSEQUÊNCE OF):									
ERT	resulting in death) LAST									
MEDICAL C	PART II. Other significant conditions	ions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED?  1 UYES 2 VNO								
		Celebro-V	onula a	undet - old.	_		1 TES 2 NO			
PHYSICIAN:		HOSPITAL:	01	28. PLACE OF DEATH (CI	heck only one)					
HYS	1 YES 2 1 NO	1 € Inpatient 2 ☐ ER/Outp		Nursing Home 5 - Residence	6 ☐ Other (Specify)	BU HIRW OCCURED				
ВУ Р	1 Netural 5 Pending	(Month, Day, Year)	INJURY	WORK? M 1 YES 2 NQ	200. DESCRIBE NOW	INJUNI OCCORED				
ETED 8	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, term, stree	t, fectory, office	28f. LOCATION (Street City or Town, State		Route Number,			
COMPLE				the time, date and place, and du- my opinion, death occured at the			(e) and manner as stated.			
BE	296. SIGNATURE AND TITLE OF CERTIFIER  Multid DL.	Dobalge !	n. O	29c. LICENSE NU	MBER	29d. DATE SIGNE	D (Month, Day, Year)			
2	30. NAME AND ADDRESS OF PERSON WHO  MICH OR DO	1 . 1		Cornecticut	Ave	Silven	Pair MA			
	31. DATE FILED (Month, Day, Year) MAR 22 93	Julia Davidson	ATURE		· .	27-17	1. 1. 1.			



BALTIMORE, MARYLAND 21215-0020

R ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. IVISION OF VITAL RECORDS, P.O. BOX 68760,

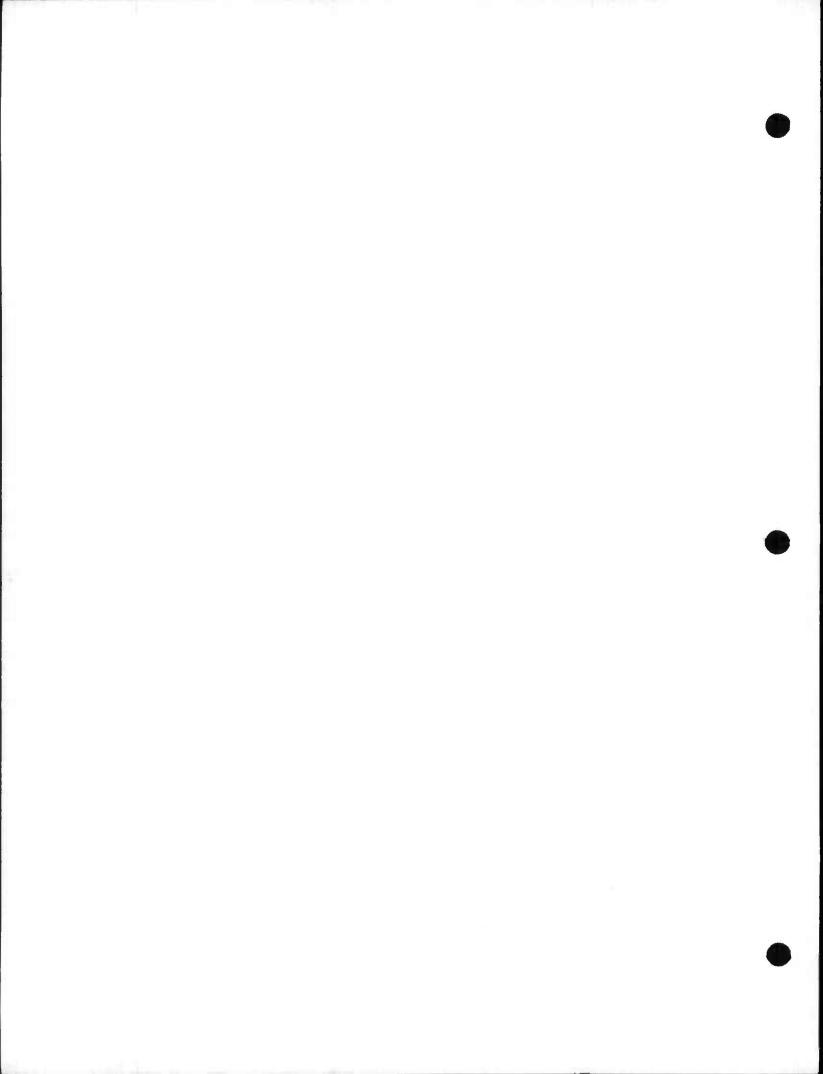
	1. DECEDENT'S NAME (First, Middle, Lest)  2. DATE OF DEATH MONTH DAY YEAR  3. TIME OF DEATH											
	HENRY MI							2:00 A M				
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs. la	st birthday)	IF UNDER		IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	1993	BIRTHPLACE (State or Foreign
	109-16-4792		1 X M 2   F	94	YAS.	MONTHS	DAYS	HOURS	MIN.	APR. 10, 189	8 61	Country) ERMANY
	9a. FACILITY NAME (If not in	stitution, give s	freet and number)			9b. CITY,	TOWN (	OR LOCATI	ON OF DE			Y OF DEATH
DIRECTOR	415 SILVER S	SPRING	AVENUE	<u>#610</u>		SIL	ER	SPRI	NG		MON	NTGOMERY
<b>H</b>	10a. STATE	10b. COUNTY			10c. CIT	Y, TOWN O	LOCAT	TION				10d. INSIDE CITY
	MARYLAND	MONT	GOMERY			SILVE						LIMITS? 1 YES 2 NO
FUNERAL	10s. STREET AND NUMBER	6 D D = 11					101	. ZIP CODI			10g. CITIZEI	N OF WHAT COUNTRY?
¥	415 SILVER	SPRING	G AVENUE  12. WAS DECEDEN					209				USA
	1 Never Merried 2 📉	Married	FORCES? 1	YES 2	NO.	H	yes, ap-	ecify Cuba	n, Mexicen	C ORIGIN? (Specify Yes , Puarto Rican, atc.)	or No 14	. RACE — American Indian, Black, White, atc.
84	3 Widowed 4 Divo	rced	IF TES, GIVE V	AN ON DATES		'	∐ YES	2 K NO	Specify:		T.	Specify: VHITE
윤	15, OEC (Specify only	EDENT'S EDUC highest grade	CATION completed)	16a. DE	CEOENT'S	USUAL OC	CUPATIO	ON et of workin		16b. KIND OF BUS	INESS/INDUS	TRY
١	Elementary/Secondary (0		College (1-4 or 5	·) life	. Do NOT us	work done d se retired.)		ar or worran	9			
COMPLETED			2	RAD	IO J	<u>OURNA</u>	LIS	T		VOICE O	F AME	RICA
	17. FATHER'S NAME (First, Mi	iddle, Last)						16. MOTI	HER'S NAM	E (First, Middle, Maiden	Sumame)	
H	19a. INFORMANT'S NAME (7)	in a Marinet		1								
임										oute Number, City or Town		•
	FREDERICK BI	ON		20b. PLACE		DOWNS			SIL	VER SPRING		20904
	1 Donation 5 Other	(Specify)	- 2	cemetery, cre METRO	metory or o	ther plece)			V			VIRGINIA
- 1	21. SIGNATURE OF FUNERAL	L SERVICE LIE	ENSEM / //	200	TOHI	22. N	AME AN	ID ADDRES	S OF FAC	ILITY		
	Mark	1.	Peller	la						LINS FUNER		
T	23. PART If Enter the di	seases, or c	omplications that	caused the de	ath. Do r	not entar	he mo	da of dvi	na. such	as cardiac or reapi	SIL. SE	PR., MD.20901
- 1	ahock, or he IMMEDIATE CAUSE (Fin	ant fellure. I	List only one cau	se on each line	h							Interval Batween Onset and Death
	disease or condition resulting in death)	<b>→</b> .	_	Cor 50	Mi	10 1	60	2.11	6.6	200		Montz 1
H	resulting in death)		DUE TO	OR AS A CONSE	DUENCE OF	F):			444			UNITE TO
<u> </u>	Sequentially list conditi	000	)									
CERTIFICATION	if any, leading to immediate. Enter UNDERLY!	liete	DUE TO	(OR AS A CONSE	DUENÇE OI	F):						
윤	CAUSE (Disease or Inju- that initiated events		DUE TO	OR AS A CONSE	DUENCE OF	F):						
	resulting in death) LAS	r										
- 19	PART II. Other significe	nt conditions	oont-thutles to	do ath had a se	in the second			T Descript				
EDICAL	TAIT II. Other algument	Z Z	T A LOT +	Geeth put not i	eaulting i	n the und	erlying	ceuse g	iven in P	Part I. 24a. WAS AN / PERFORI		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
ו בֿ			2/11/9	100						1 YES 2	NO	COMPLETION OF CAUSE OF DEATH?
Σ										_		1 TES 2 NO
HYSICIAN	25. WAS CASE REFERRED TO	MEDICAL T	_				26 DI	ACE OF DE	EATH (Char	ck only one)		
2	EXAMINER?		HOSPITAL:	FR/Outpetlant 3	□ noa	OTHER						
	27. MANNEB OF DEATH		28a. DATE OF	INJURY	26b. TIM	E OF	8c. INJ			Other (Specify)  26d. DESCRIBE HOW IN	JURY OCCUR	FD
7		Pending nvestigation	(Month, Da	ty. Year)	INJ	URY M	1   Y	RK? 'ES 2 [				
- 8		gation		F INJURY — At ho	me, larm, a	freet, lacto	y, office			281. LOCATION (Street at	nd Number or I	Rural Route Number,
- 4	3 Suicide 6 6	Could not be	288. PLACE OF	etc (Specify)								
	= "	Could not be letarmined	building,	atc. (Specify)						City or Town, State)		
PLEIED	4 Homicide  29a. CERTIFIER (Check only)	letarmined	building,	atc. (Specify)	ath occurre	d at the lin	ie, data	and place,	and due to		ner as stated.	
Σ∥	4 Homicide  29a. CERTIFIER (Check only)  1 CERTIFIER	IFYING PHYSIC	ZIAN: To the best of	my knowledga, de						o the cause(s) and mani		ause(a) and manner as stated.
5	4 Homicide  29a. CERTIFIER (Check only)  1 CERTIFIER	IFYING PHYSIC	ZIAN: To the best of a:	my knowledga, de				with occur		o the cause(s) and mani	dua to the co	ause(a) and manner as stated.  GNED (Month, Dey, Year)
	4 Homicide  29a. CERTIFIER (Check only one) 2 MEDIU  29b. SIGNATURE AND TITLE-	SET OF CENTIFIER	CIAN: To the best of a: On the basis of ax	my knowledga, de amination and/or (	rivestigatio	n, In my op		with occur	ed at the ti	o the cause(s) and mani	dua to the co	
Σ∥	29a. CERTIFIER (Check only one) 1 CERTI	IFYING PHYSIC CAL EXAMINER OF CERTIFIER PERSON WHO	CIAN: To the best of a: On the basis of ax	my knowledga, de amination and/or (	rivestigatio	n, In my op		with occur	ed at the ti	o the cause(s) and mani	dua to the co	
	4 Homicide  29a. CERTIFIER (Check only one) 1 CERTI (Check only one) 2 MEDIU  29b. SIGNATURE AND TITLE-  30. NAME AND ADDRESS OF	FYING PHYSIC CAL EXAMINER OF CERTIFIER PERSON WHO	CAN: To the best of at the best of a	my knowledga, de amination and/or (	nvestigatio	n, In my op		with occur	ed at the ti	o the cause(s) and mani	dua to the co	



SPIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

The control of the control of the control of the attention physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be attention of the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit per

	1 - STATE REGISTRAR	STATE OF MARYL		MENT OF H		MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH		
	KATHERINE	JoANN	NIEFE	ELD		MARCH 21	1993			
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. B	IRTNPLACE (State or Foreign		
	212-24-4266	1 🗆 M 2 💢 F	53 YRS.	ONTHS DAYS	HOURS MIN.	(Month, Day, Year) JUNE 19,19	C	OUNTRY) ENNSYLVANIA		
	9a. FACILITY NAME (If not institution, give s			96. CITY, TOWN C	R LOCATION OF DE		9c. COUNTY C			
DIRECTOR	11813 TIMBER LAN	E		ROCKV	ILLE		200 11000 10	GOMERY		
EG	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNT	Y	10c CITY	TOWN OR LOCAT	ION			Level many areas		
H	MARYLAND MON'	TGOMERY			2550			10d. INSIDE CITY LIMITS?		
	10e. STREET AND NUMBER	IGOMEKI	R	OCKVILLI	ZIP CODE		AC- OFFICE	1 YES 2 NO		
FUNERAL	11813 TIMBER LANE				20852					
Ž	11. MARITAL STATUS	12. WAS DECEDENT EVER II	N U.S. ARMED	13 WAS DEC		IC ORIGIN? (Specify Yes	USA	RACE — American Indian,		
	1 Never Married 2 Married	FORCES? t YES	5 NO	II yes, spi		, Puerto Rican, etc.)		Black, White, etc.		
В	3 📉 Widowed 4 🗌 Divorced			1 1 123	ZA_ NO Specify.			Specify: VHITE		
	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S U	SUAL OCCUPATION And done during most	ON staffweding	16b. KIND OF BUS				
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT use	retired.)	st or working					
MP		2	DEPUTY C	LERK OF	COURT	MONTGOM	ERY COU	NTY		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAM	AE (First, Middle, Malden	Surname)			
BE	JOSEPH ROGE	RS			KATHER	RINE PI	ERCE			
2	19a, INFORMANT'S NAME (Type/Print)		19b. MAILING A	DDRESS (Street a	nd Number or Rural A	oute Number, City or Town	n, State, Zip Code	)		
	TODD A. NIEFELD	(SON)	110 E.	INDIAN	SPRING D	RIVE SIL	VER SPR	RING, MD. 20901		
	20e METNOD OF DISPOSITION 1 △ Buriel 2 □ Cremellon 3 □ Rem	oval from Stale Carr	PLACE AND DATE OF	ar place)			CATION — City o	Control of the Control		
.	4 Donation 5 Other (Specify) 21_ SIGNATURE OF FUNERAL SERVICE LIX	GI	ORGE WASI	INGTON		3/24 ADE	LPHI, M	IARYLAND		
	21. SIGNATURE OF PUNERAL SERVICE DE	PNSEE /		FRANC	S J. COT	LINS FUNE	RAT. HOM	IE. INC.		
	Seatt L.S	male						R.,MD.20901		
	23. BARTY1. Enter the diseases, or o	complications that caused List only one cause on a	tha death. Do no	t antar the mo	da of dying, such	as cerdiac or reaple	ratory arrest,	Approximate		
	IMMEDIATE CAUSE (Final							Interval Between Onset and Dagth		
	disease or condition resulting in death) A METASTATIC CARCINOMA 4me									
	DUE TO (OR AS A CONSEQUENCE DF):									
N	Sequentially list conditions									
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING									
FIC	CAUSE (Disease or Injury	C. DUE TO (OR AS A	CONSEQUENCE OF:							
Ē	that initiated evente resulting in death) LAST									
CE		d								
AL.	PART II. Other eignificant condition	e contributing to death b	ut not reculting in	the underlying	cauae given in F	Part I. 24s. WAS AN A		24b. WERE AUTOPSY FINDINGS		
음						t 🗆 YES 2		AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?		
ME								1 TES 2 NO		
ž										
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			ACE OF DEATN (Che	ck only one)				
YSI	1 TYES 2 NO	1  Inpetient 2 ER/Outp	atient 3 DOA 4	OTHER:	5 Residence (	3 ☐ Other (Specify)				
F	27. MANNER OF DEATN  1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	26b. TIME		JRY AT	28d. DESCRIBE HOW IN	JURY OCCURED			
B≺	2 Accident Investigation				ES 2 NO					
	3 Suicide 6 Could not be 4 Nomicide determined	28e. PLACE OF INJURY building, etc. (Spec	- At home, farm, stre	eet, factory, office		28t. LOCATION (Street m City or Town, State)	nd Number or Ru	ral Route Number,		
	An arearing									
COMPLETED		CIAN: To the best of my knowl								
S.	2 MEDICAL EXAMINE	R: On the basis of examination	and/or investigation,	In my opinion, de	eth occured at the I	lme, date and place, and	due to the cau	se(e) and manner as stated.		
BE (	29b. SIGNATURE AND TITLE OF CERTIFIER	2 1.1	2	<u> </u>	29c. LICENSE NUM		29d. DATE SIGN	NED (Month, Day, Year)		
5	cuful 1	P. 710	re no		2094	70	Mar	12, 1883		
	30. NAME AND ADDRESS OF PERSON WIN	O COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, P	rine) 10	400 1	CONNECT	TIEUT	20 Fes-		
	EUGENE Y	- LIDRE	M.O.	/	KENVI	NECON,	MD	20 895		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE D							
- 1	27 30	d ha Davidson	A Property							



BALTIMORE, MARYLAND 21203-3146

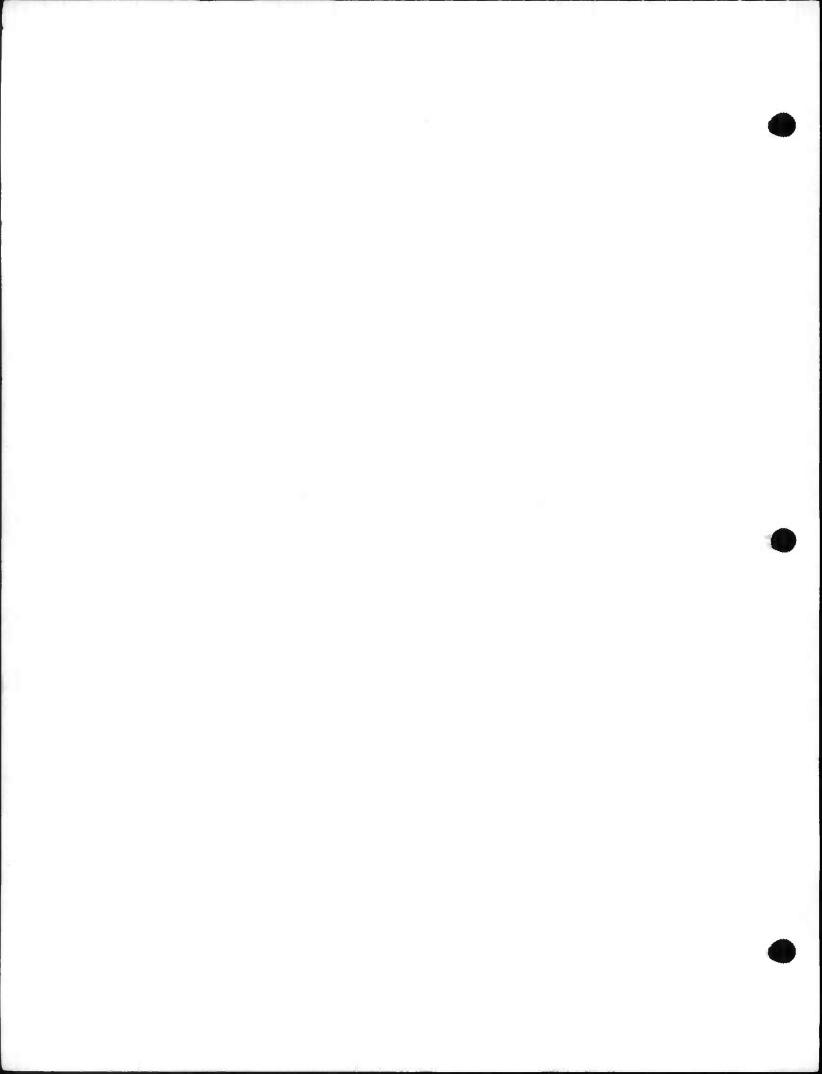
SEPTAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24, radius after death. Page 6 may be retained by the hospital or attending physician.

INCAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should him 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

ANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR			CERTIF	ICATE	: OF	DEATH		REC	G. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)			- 0					TE OF DE			34	3. TIME OF DEATH	$\neg$
	Erika A	M	. 1					10000	NTH	DAY		YEAR	2.05	м
			line					-	RCH		.199		2.03 A	_
			. AGE (In yrs.	lest birthday)	IF UNDER	DAYS	IF UNDER 24 HRS.	7. DA	TE OF BIR	TH Year)		6. BIRT	HPLACE (State or Foreign	- 1
	578-62-0072	1 M 2 F	102	YRS.				MAY	7 9	189	0	NOF	RWAY	_
	9a. FACILITY NAME (If not institution, give stre	et and number)			9b. CITY,	TOWN D	R LOCATION OF D	PEATH				NTY OF		
Œ	SYLVAN MANOR HEAL	מוז כאחדי כ	,	CTI	מקוז	CDDTNO							- 1	
임	RESIDENCE OF DECEDENT	In CARE C	ENTER	(	PIL	VEK	SPRING				MONT	GOM	CRY	-1
DIRECTOR	10s. STATE 10b. COUNTY 10c. CITY, TOWN DR LOCATION 10d. INSIDE CITY												10d. INSIDE CITY	╛
<u>E</u>	MADVI AND MONT	COMPA										LIMITS?	-1	
		GOMERY_		<u> 1 S</u>	ILVE	-							1 YES 2 NO	4
A	10e. STREET AND NUMBER					101	. ZIP CODE				10g. CIT	IZEN OF	WHAT COUNTRY?	-1
ᄄ	10820 GEORGIA AVEN	IUE #204					209	902					USA	-1
FUNERAL		12. WAS DECEDENT E	EVER IN U.S.	ARMED	13, 1	MAS DEC	ENDENT OF HISPA	<del>, , , , , , , , , , , , , , , , , , , </del>	GIN? (Spe	cify Yes	or No—	14. RAC	E — American Indian, k, White, etc.	⇥
	1 Never Married 2 Married	FORCES? 1 FYES, GIVE WAR		NO			ecify Cuben, Mexic		to Rican, o	etc.)				-1
B	3 X Widowed 4 Divorced	IF TES, GIVE WAR	OH DATES		'	YES	2 ND Speci	wy:				Spec	iny. IITE	-1
	15, DECEDENT'S EDUCA	TION	140.	DECEDENT'S			N	1.	18b. KIND	05 0110	101500 11011		1115	
끧	(Specify only highest grade of		10a.	(Give kind of	work done o	during mo	st of working	- 1	100. KIND	OF BUS	INESS/IN	JUSTRY		- 1
<b>Ш</b>	Elementary/Secondary (0-12)	College (1-4 or 5+)		life. Do NOT u										-1
<u>a</u>		2	R	EGISTE	RED 1	NURS	E							_
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S N	AME (Fire	st, Middle,	Maiden S	Surname)			
	PETER PETER		TOTIAN	A TATA										
BE	19a, INFORMANT'S NAME (Type/Print)	/Ptennt o	JOHAT  and Number or Rural		umbas Ch	an Town	Canto 71	- Codel		$\dashv$				
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	ELLEN NESLINE	(DAUGH)	rer)	10820	GEO	RGIA	AVENUE	#20	4 SI	LVE	R SP	RING	.MD 20902	ച
	20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Remove	ml form Chab	20b. PLA	CE OF DISPO	SITION (Ne	me of cer	metery, crematory or			20c. LOC	CATION —	City or T	own, State	
	4 Donation 5 Other (Specify)	val from State		AR HIL	I CEN	arte A	DV			CIIT	TT A NT	D 14	ARYLAND	-1
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE	OLIDI	MC IIIL	22.	NAME A	ND ADDRESS OF F	ACILITY		SUI	LLAN	11 , IV	ARYLAND	$\neg$
		200		1	F	RANC	IS J. CO	OLLI	NS F	UNE	RAL	HOME	, INC.	-1
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL.SPR., MD. 20												. MD 20901	H
	23. PART I. Enter the diseases, or co	on plications that o	caused the	death. Do	not antar	tha mo	da of dving, su	ch aa c	ardiec o	r reepi	ratory ar	rest.	Approximate	
	shock, or heart failure. L	4		1										4
	oncon, or near transfer E	MET Only one cause	on each	line.									interval Between	
	IMMEDIATE CAUSE (Final	set only one cause	on each										Interval Between Onset and Death	
	IMMEDIATE CAUSE (Final disease or condition	set only one cause	on each		ein	100								
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	IMMEDIATE CAUSE (Final disease or condition	Da	ude	Am	LIM PFI:	1011	<u>'</u>							
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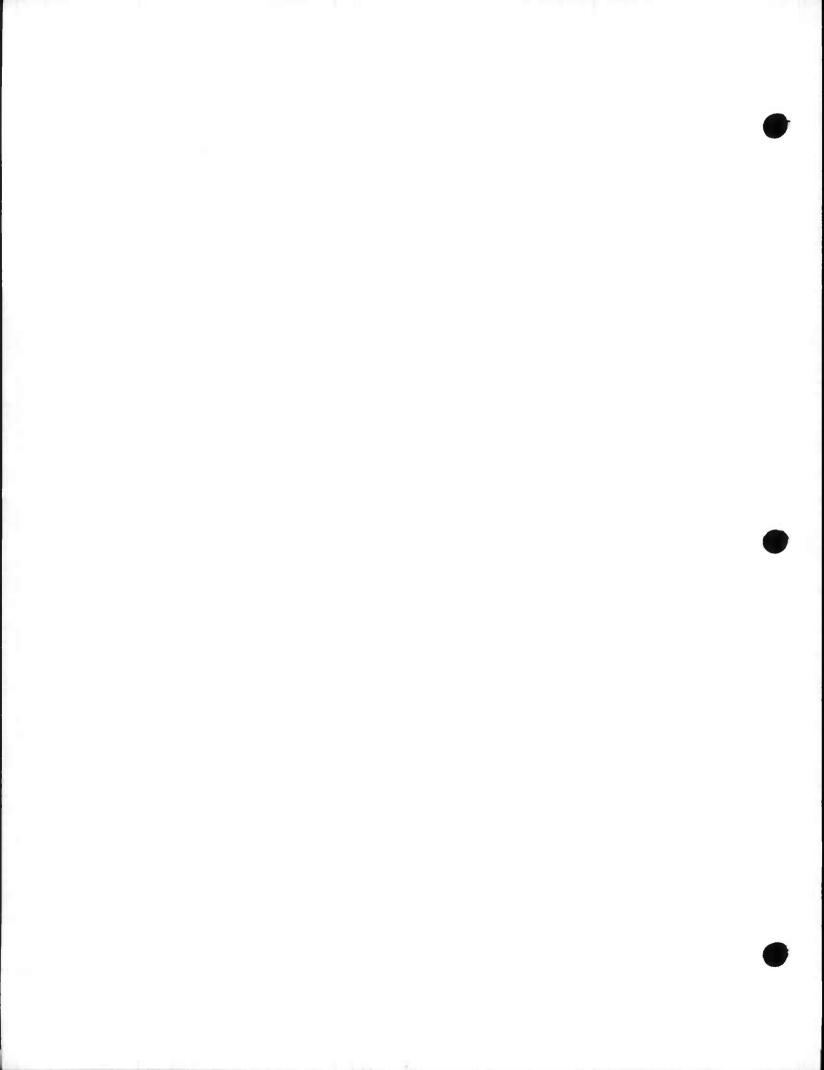
DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
TO PRE-MOSPIAL DR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician.

TO THE ELECAL DIRECTOR: After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be interwrinin 72 bours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or liem 23 shows any injury, or other traumatic event, the medical exeminer must be notified at once.

FOR 1 - STATE PEGISTRAP STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	ACGISTAAN			-14141	ICATE	/ DEA		REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last, MIEN OUNG						3	DATE OF DEATH	AY S		3. TIME OF DEATH 10:55 A
	4. SOCIAL SECURITY NUMBER	5. SEX 6. /	AGE (In yrs. les	t birthday)	IF UNDER 1 YE		R 24 HRS. 7.	DATE OF BIRTH		8. BIRTHP	LACE (State or Foreign
1 3	579-82-2918	1 💢 M 2 🗆 F	61	YRS. MONTHS DAYS HOURS MIN. 3				(Morith, Day, Year) 3/13/32	(Month, Day, Year) Country) 3/13/32 Cambod:		
	Sa. FACILITY NAME (If not institution, give		n: 40]				ION OF DEATH			NTY OF DE	ATH
O.	Montgomery Ge	neral Hos	pitai		OIn	= y			Mont	tgom	ery
밀	RESIDENCE OF DECEDENT  10a. STATE 10b. COUN	ry		10c. CIT	Y, TOWN OR L	CATION					10d. INSIDE CITY
DIRECTOR	MD Mont	gomery		200	lver S						LIMITS?
	10e. STREET AND NUMBER	-				101. ZIP COL	Œ		10g. CITI		HAT COUNTRY?
ER.	13800 New Hamps	shire Avenu	е		_	2090	14		Unit	ted S	States
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EV	ER IN U.S. AR	MED	13. WAS	DECENDENT	OF HISPANIC	ORIGIN? (Specify Yes		14. RACE	- American Indian, White, etc.
B	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR				YES 2 X NO		verte rican, etc.)		Specify	
崖	15. DECEDENT'S ED (Specify only highest grad	UCATION le completed)	(Gi	ve kind of a	USUAL OCCUI	ATION most of work	ing	16b. KIND OF BU	SINESS/IND	USTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+) 5+		iest	e retired.)			D .			
NO.	17. FATHER'S NAME (First, Middle, Last)		FI	rest	_	10 4400	WED'S NAME	Pries			
	Unobtainable						obtair		Surrieme)		
) BE	19a. INFORMANT'S NAME (Type/Print)		196	, MAILING	ADDRESS (St			te Number, City or Tow	m, State, Zip	Code)	
2	Tarun Khemradhi	pati						con Hill,			20745
	20a. METHOD OF DISPOSITION 1 ☐ Burlal 2X☐ Cremation 3 ☐ Real	novel from State		ND DATE	OF DISPOSITIO			DATE 20c. LO	CATION —	City or Tow	rn, State
	4 Donation 5 Other (Specify)	_			oln Cr	emator	y 3/2	7 9 3	twood	d, Ma	ryland
1 1	21. SIGHATURE OF FUNERIAL SERVICE L	(1)	<b>シ</b>				o 1 dd 1		I		
Ш	Hines-Rinaldi Funeral Home  11800 New Hampshire Ave., Silver Silv										
	23. PART i. Enter the diseases, pr shock, or heart failure	compilcations that ca	used the de	ath. Do r	ot enter the	mode of dy	ring, such a	s cardiac or resp	iratory arr	est,	Approximata Interval Between
	iMMEDIATE CAUSE (Final disease or condition										Onset and Death
	disease or condition resulting in death)  a. Cardio sulmonary arrest										24 hours
-	_		emia	IVENCE U	-):	/					i 1
CERTIFICATION	Sequentially list conditions, if any, leading to immediate		AS A CONSEC	WENCE OF	<b>7</b> :						
3	cause, Enter UNDERLYING CAUSE (Disease or injury	c Sel	AS A CONSEC								
E	that initiated events resulting in death) LAST	DUE TO (Of	AS A CONSEC	WENCE OF	7:						
馬	Toolang in death, Exc.	d		_							
	PART ii. Other significant condition	ns contributing to dea	th but not re	esuiting	n the under	ying cause	given in Par	rt i. 24e. WAS AN			WERE AUTOPSY FINDINGS
EDICAL								1 TYES 2			AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
WE									~	- 1	1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER:	S. PLACE OF I	DEATH (Check	only one)			
ΥS	1 VES 2'S NO 27, MANNER OF DEATH	28e. DATE OF INJS			4 - Nursing			Other (Specify)			
	1 Natural 5 Pending	(Month, Day, Y		28b. TIM INJ	URY	INJURY AT WORK?		id. DESCRIBE HOW I	NJURY OCC	CURED	
BY	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF IN.	JURY — Al ho	me, farm, i				If. LOCATION (Street	end Number	or Rural Ro	ute Number
TED	4 Homicide determined	building, etc.	(Specify)				1 300	City or Town, State)	i i i i i i		F- 9.1-100
7	29a. CERTIFIER (Check only	SICIAN: To the best of my	knowledge, de	oth occum	ed at the time,	date end place	a, and due to t	the cause(e) and mar	nner as state	ed.	
COMPLET		Et: On the basie of exami									and manner ee stated.
BE	29h. SIGNATURE AND TORE OF CENTRE	DR KEI	LERT			\ \ \	LOS 7		29d. DATE	E SIGNED	Month, Day, Year)
유	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE O	F DEATH (ITEN	1 27) (Type,	Print)				>1	10/7	>
	10 \ V. il -	4000	Olney	La	Stone	ille.	RP.	Olney	ma	0, 2	0832
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S	SIGNATURE	md na	/			-			
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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

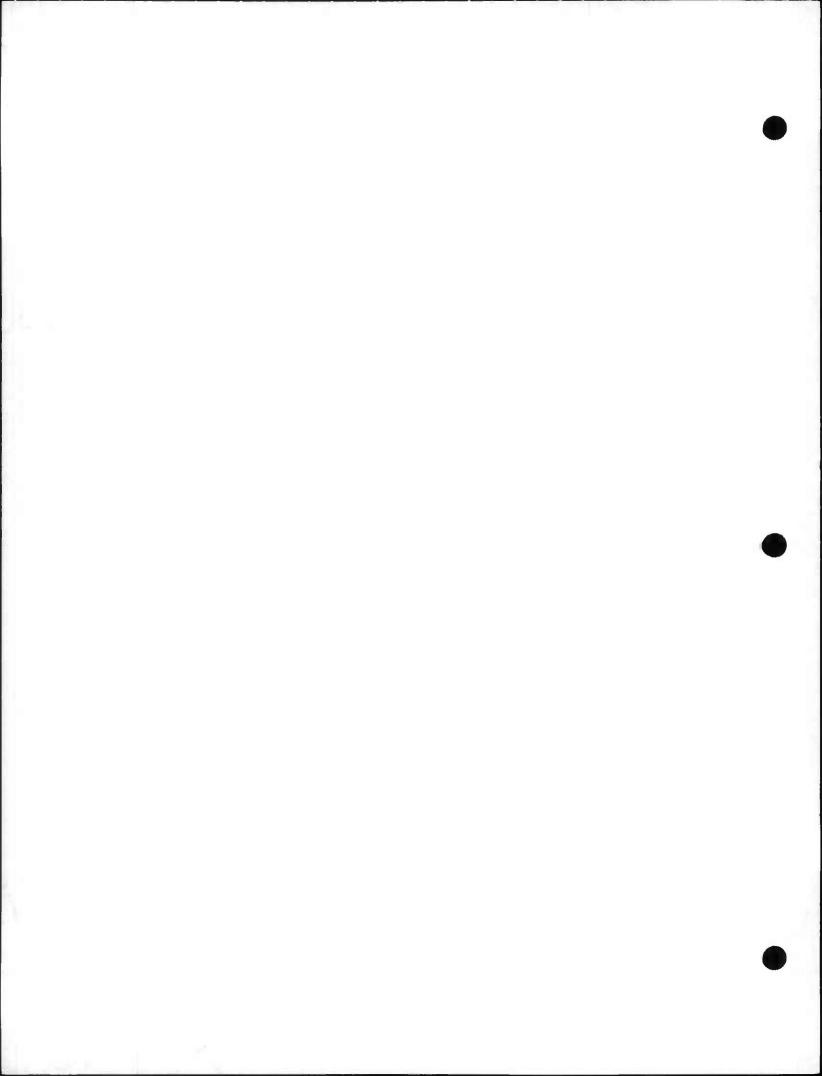
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

93 09746 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1 -1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATN YEAR

	Phi					Mar 2	0,19	93   8:47 Am M			
i i	4. SOCIAL SECURITY NUMBER		GE (In yrs. lest birthd		IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	1	BIRTNPLACE (State or Foreign Country)			
		1 € M 2 □ F	6 YR	S. MONTHS DAYS	HOURS MIN.	Jul 11.1	Maryland				
	9a. FACILITY NAME (If not institution, give st	treet and number)		9b. CITY, TOWN	OR LOCATION OF DEA			TY OF DEATH			
E	455 College	Domino									
K	RESIDENCE OF DECEDENT	Parkway		I ROC	KATITE		Mon.	tgomery			
DIRECTOR	10e. STATE 10b. COUNTY		10c.	CITY, TOWN OR LOCA	TION			10d. INSIDE CITY			
5	Maryland Mont	aomerv		Rockvil	10			LIMITS? 1 ☑ YES 2 ☐ NO			
	10e. STREET AND NUMBER	domera			1. ZIP CODE		10m CITIZI	EN OF WHAT COUNTRY?			
2	455 6 11			"							
FUNERAL	455 Colle	qe Parkwa			20850			.S.A.			
5	1X Never Married 2 Married	12. WAS DECEDENT EVE FORCES? 1 2	RIN U.S. ARMED	13. WAS DE If yes, a	CENDENT OF HISPANII pecify Cuben, Mexican,	C ORIGIN? (Specify Yes Puerto Rican, etc.)	or No— 1	4. RACE — American Indian, Black, White, etc.			
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OF	R DATES	1 🗌 YE	2 NO Specify:			Specify:			
	15. DECEDENT'S EDUC	DATION .	1 40 - 200	<u> </u>		-T		Black			
COMPLETED	(Specify only highest grade		(Give kind	IT'S USUAL OCCUPATI of work done during m of use retired.)	ON ost of working	16b. KIND OF BUS	INESS/INDU	STRY			
۳	Elementary/Secondary (0-12)	College (1-4 or 5+)				44-4-4					
Σ			Stu	dent		None					
8	17. FATNER'S NAME (First, Middle, Last)				18. MOTNER'S NAM	E (First, Middle, Meiden :	Sumame)				
8	Johnny Otis	Payne			Kar	en Dill	ard				
	19a, INFORMANT'S NAME (Type/Print)	Mother)	19b, MAIL	JING ADDRESS (Street	and Number or Rural Ro	oute Number, City or Town	, State, Zip C	Code) 20850			
2	Mrs Karen Pavn	6	45!	5 Collec	e Parkw	ay, Rock	ville	e, Md			
	20a. METHOD OF DISPOSITION			TEOF DISPOSITION (N		-	_	lty or Town, State			
	1 X Burial 2 Cremation 3 Remo	oval from State	cemetery, crematory	or other place) f Heaver	Com			Spring, Md			
1	21. SIGNATURE OF FUNERAL SERVICE/LIC	EHSER	Jace O		ND ADDRESS OF FACE			1 = 57			
- 1	( ) ()	11. 1	1	Sno	wden Fu	neral Ho	me P	.A. 20850			
_	+SMIE KY	Many	ur	246	N. Was	hington	St, I	Rockville, Md			
	23. PART i. Enter the diseases, or c shock, or heart failure.	omplications that cau	sed the death. D	o not enter the me	ode of dying, such	as cardiac or reapir	atory arre				
	THE RESPONDED TO THE RESPONDED TO THE PARTY OF THE PARTY	Wilms	Tumor					interval Between Onset and Death			
	disease or condition										
	resulting in death)	DUE TO (OR (	S A CONSEQUENCE	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				- YGATS			
_ 1	_			- 0. ).				/			
ó	Sequentially list conditions,	DUF TO (OR 4	S A CONSEQUENCE	F OF:							
A	if any, leading to immediate cause. Enter UNDERLYING			,.				1			
윤	CAUSE (Disease or injury that initiated events	DUE TO (OR #	S A CONSEQUENCE	E OFI:							
E	resulting in death) LAST										
8		1									
AN: MEDICAL CERTIFICATION	PART II. Other algnificent condition	s contributing to deet	h but not reeuitin	ng in the underlyin	g cause given in P	ert I. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS			
2						PERFOR		AMAJLABLE PRIOR TO COMPLETION OF CAUSE			
						1 TYES 2	Σζ MO	OF DEATH?			
Σ						_		1 NES 2 NO			
A N	25. WAS CASE REFERRED TO MEDICAL										
	EXAMINER?	HOSPITAL:			LACE OF DEATH (Chec	k only one)					
2 1	Ed. 1 E-10E Of DEATH (Orack Only Orac)										
YSIC			28b		JURY AT	28d. DEŞCRIBE NOW IN	JURY OCCU	RED			
PHYSIC	27. MANNER OF DEATH		1X Natural 5 Pandler (Month, Day, Year) NJJRY WORK?								
N PHYSIC	27. MANNER OF DEATH  1. Netural 5 Pending			4.4	YES 2 NO		Sf. LOCATION (Street and Number or Rural Route Number,				
B	27. MANNER OF DEATH  1 Netural 5 Pending	(Month, Day, Yea	JRY — At home, fair	4.4	YES 2 NO	281. LOCATION (Street of	nd Number o	r Rural Route Number,			
ED BY	27. MANNER OF DEATH  1. Netural 5 Pending 2 Accident Investigation	(Month, Day, Yea	JRY — At home, fair	M 1 🗆	YES 2 NO	281. LOCATION (Street in City or Town, State)	nd Number o	r Rural Route Number,			
ED BY	27. MANNER OF DEATH  1. Netural 5 Pending Investigation  3 Suicide 8 Could not be determined	(Month, Day, Yea 28e. PLACE OF INJU- building, etc. (S	JRY — At home, fan	M 1m, street, factory, offic	YES 2 NO	City or Town, State)					
ED BY	27. MANNER OF DEATH  1 Netural 5 Pending Investigation  3 Suicide 6 Could not be determined  29a. CERTIFIER (Check only)  27. MANNER OF DEATH  5 Pending Investigation  6 Could not be determined	(Month, Day, Yea 28e. PLACE OF INJU- building, etc. (S	JRY — At home, fan Specify)	m, street, factory, offic	YES 2 NO	City or Town, State)  the cause(s) and men	ner as stated	ı.			
ED BY	27. MANNER OF DEATH  1 Netural 5 Pending Investigation  2 Accident 8 Could not be determined  296. CERTIFIER (Check only one) 2 MEDICAL EXAMINEI	(Month, Day, Yea  28e. PLACE OF INJL  28e. PLACE OF INJL  building, etc. (S  CIAN: To the best of my kr  R: On the best of examine	JRY — At home, fan Specify)	m, street, factory, offic	YES 2 NO	City or Town, State)  the cause(s) and men	ner as stated				
COMPLETED BY	27. MANNER OF DEATH  1 Netural 5 Pending Investigation  3 Suicide 6 Could not be determined  29a. CERTIFIER (Check only)  27. MANNER OF DEATH  5 Pending Investigation  6 Could not be determined	(Month, Day, Yea  28e. PLACE OF INJL  28e. PLACE OF INJL  building, etc. (S  CIAN: To the best of my kr  R: On the best of examine	JRY — At home, fan Specify)	m, street, factory, offic	YES 2 NO	City or Town, State)  o the cause(s) and men me, date and place, and	ner as stated	ı.			
BE COMPLETED BY	27. MANNER OF DEATH  1. Netural 5 Pending Investigation  3 Suicide 6 Could not be determined  29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE!  29b. SIGNATURE AND TITLE OF CERTIFIER	(Month, Day, Yea  28e. PLACE OF INJI building, etc. (S  CIAN: To the best of my kr R: On the bests of examina	JRY — At home, fan  JRY — At home, fan  nowledge, death occ ation end/or investig	M 1 m, street, factory, officerred at the time, date patient, in my opinion, section, section, sec	YES 2 NO	City or Town, State)  o the cause(s) and men me, date and place, and	ner as stated I due to the 29d, DATE	t. cause(s) and manner as stated.			
COMPLETED BY	27. MANNER OF DEATH  1 Netural 5 Pending Investigation  2 Accident 8 Could not be determined  296. CERTIFIER (Check only one) 2 MEDICAL EXAMINEI	(Month, Day, Yea  28e. PLACE OF INJI building, etc. (S  CIAN: To the best of my kr R: On the bests of examina	JRY — At home, fan  JRY — At home, fan  nowledge, death occ ation end/or investig	M 1 m, street, factory, officerred at the time, date patient, in my opinion, section, section, sec	YES 2 NO	City or Town, State)  o the cause(s) and men me, date and place, and	ner as stated I due to the 29d, DATE	t. csuse(s) and manner as stated. SIGNED (Month, Day, Year)			
BE COMPLETED BY	27. MANNER OF DEATH  1. Netural 5 Pending Investigation  3 Suicide 6 Could not be determined  29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE!  29b. SIGNATURE AND TITLE OF CERTIFIER	(Month, Day, Yea 28e. PLACE OF INJU- building, etc. (S CIAN: To the best of my kr R: On the bests of examina	JRY — At home, fan Specify)  nowledge, death occ ation end/or investig	M 1 m, street, factory, officerred at the time, date patient, in my opinion, section, section, sec	YES 2 NO	City or Town, State)  o the cause(s) and men me, date and place, and	ner as stated I due to the 29d, DATE	t. csuse(s) and manner as stated. SIGNED (Month, Day, Year)			
BE COMPLETED BY	27. MANNER OF DEATH  1. Netural 5 Pending Investigation  2 Accident 6 Could not be determined  29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINES  29b. SN ATURE AND TITLE OF CERTIFIER  30. MAIL AND ADDRESS OF PERSON WHO	28e. PLACE OF INJI 28e. PLACE OF INJI building, etc. (S  CIAN: To the best of my kr R: On the best of examina  COMPLETED CAUGE OF  32. REGISTRAR'S S	JRY — At home, fan  JRY — At home, fan  powledge, death occ  attori end/or investig  DEATH (ITEM 27) (I	m, street, factory, officeurred at the time, date pation, in my opinion, in the pation, in the pation, in the pation of the pati	YES 2 NO	City or Town, State)  o the cause(s) and men me, date and place, and	ner as stated I due to the 29d, DATE	t. csuse(s) and manner as stated. SIGNED (Month, Day, Year)			
BE COMPLETED BY	27. MANNER OF DEATH  1. Netural 5 Pending Investigation  2 Accident 8 Could not be determined  29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINES  29b. SIGNATURE AND TITLE OF CERTIFIER  30. MARE AND ADDRESS OF PERSON WHO	28e. PLACE OF INJI 28e. PLACE OF INJI building, etc. (S  CIAN: To the best of my kr R: On the best of examina  COMPLETED CAUGE OF  32. REGISTRAR'S S	JRY — At home, fan Specify)  nowledge, death occ atton end/or investig  DEATH (ITEM 27) (1	m, street, factory, officeurred at the time, date pation, in my opinion, in the pation, in the pation, in the pation of the pati	YES 2 NO	City or Town, State)  o the cause(s) and men me, date and place, and	ner as stated I due to the 29d, DATE	t. csuse(s) and manner as stated. SIGNED (Month, Day, Year)			

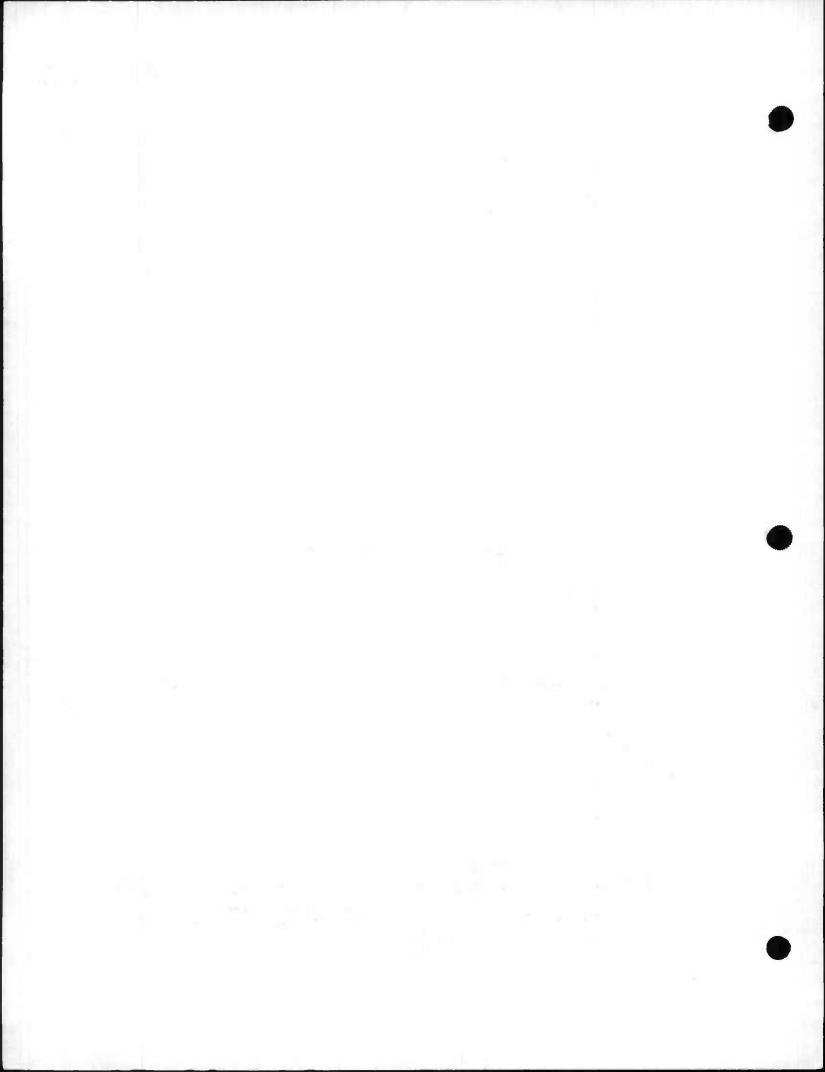
DNMN-16 Rev 1/89



BALTIMORE, MARYLAND 21215-0020	MSICIAN: The law requires that the death certificate be executed within 24 frours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should in the State Debt, of Health and Mental Hypiene prior to bunial, cremation, or removal.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24	TO THE NUMERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f be filled within 72 hours after death with the State Debt, of Health and Mental Hygiene prior to burial, cremation, or cempal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR		STATE OF I	MARYL		DEPART ERTIFI					MENT		<b>YGIEN</b> EG. NO.	E .	3	09	747
	1. DECEDENT'S NAME (First,		Μ.		P	URT			UG		3	TE OF D	EATH DA	7	YEAR 93	3. TIME O	PM
	577842 98. FACILITY NAME (If not in	434	1 D M 2 KF 93 YRS. MONTHS DAYS HOURS MIN. 3-13-00 NOT								W/c	te or Foreign					
DIRECTOR	CARRIAGE RESIDENCE OF DEC	Silv							MONTGOMER			RY					
IRE	Maryland	19b. COUNT	v itgomery				rown or									10d. INSIC	\$7
	10e. STREET AND NUMBER	1101	regomery			1 21.	rver	-	ZIP COD	E				10g. CIT	IZEN OF W	1 YES	2 NO
FUNERAL	9101 2nd	Avenu						2	0910	)				U.S	.A.		
B	11. MARITAL STATUS  1  Never Merried 2  3  Widowed 4  Divo		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES	2 X P		If y	s, spe	city Cube	OF HISPA en, Mexica Specifi	in, Puert	GIN? (Sp o Rican	ecify Yee , etc.)	or No—	14. RACE Black Specif	- America, White, else White	
8	15, DEC (Specify only	EDENT'S EDU	CATION completed)		16a. DE	CEDENT'S U	SUAL OCCU	PATIO	N t of worldi	na	1	6b. KINI	OF BUS	INESS/IN	DUSTRY		_
COMPLETED	Elementary/Secondary (0		College (1-4 or 6	+)		Do NOT use ISEWI						Own	Hon	ne .			
	17. FATHER'S NAME (First, M.	sper	Connell	37					18. MOT	HER'S NA							
BE	19a. INFORMANT'S NAME (7)		Oomeri	<u>y</u>	198	b. MAILING /	DDRESS (S	treet en	id Number		rgar		Cu		Codel	_	
2	Frances Pit	tle														ing,	MD 209
	20s. METHOD OF DISPOSITI	n 3 🗆 Rem	oval from State	20t	netery, cre	MDDATEON Metory or oth Lawn	DISPOSITION	ON (Nar	ne of			\TE			City or To		
	4 Donation 5 Other 21. SIGNATURE OF FUNERAL		CENSEE		Park	Lawn					3-	22]	Rock	vill	e, M	D	
	> les Af	Inker	ton				J0:	SEP 30	H GA Wisc	SS OF FA	R'S	SON	S IN	C.	oton	DC	20016
ION	23. PART I. Enter the di ahock, or he IMMEDIATE CAUSE (Fin disease or condition resulting in death)  Sequentielly list conditi if any, leading to immed	ons, fallure.	a. PULA DUE TO	OR AS	AR)		MBC			ing, auc	th an ca	ardiec (	or reapli	ratory arr	reat,	Ons	roximate val Between et and Death
CERTIFICATION	cause. Enter UNDERLYI CAUSE (Disease or Inju that Initiated events resulting in death) LAS	ng ry	e	(OR AS A	A CONSEC	DUENCE OF)											
MEDICAL	PART II. Other algoritice G.I. HE ANEMI	HOPP	na contributing to	death b	out not r	eaulting in	the unde	rlying	ceuse (	given in	Part I.		WAS AN A PERFOR	MED?		AVAILABLE	N OF CAUSE
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:					26. PL/	CE OF D	EATH (Ch	eck only	one)					
YSI	1   YES 2   NO		1 Inpatient 2		patient 3	□ DOA .	THEM:	Home	5 🗆 Ra	esidence	6 🗆 OH	her (Spe	cify)				
		Pending	26a. DATE OF (Month, D			26b. TIME INJU	RY	WOF	RY AT K? ES 2	7.NO	28d. D	ESCAIB	E HOW IN	JURY OC	CURED		
TED BY	3 Suicide 6	nvestigation Could not be letermined	28e. PLACE O building,	F INJURY atc. (Spec	( — Al hor	me, farm, atr							(Street a	nd Number	or Rural A	oute Numbe	τ,
COMPLET			CIAN: To the best of													end menn	er as stated.
BE	291 SIGNATURE AND TITLE			To	1	)			29c. LICI	ENSE NUI	MBER					(Month, Day	
2	30. NAME AND ADDRESS OF		O COMPLETED CAUS		ATH (ITEM	427) (Type, F	rint) 4	701		AND			RI	> > /	54 17	TE 2	16
	31. DATE FILED (Month, Day )	<b>19</b> 3	32. REGISTRA		ATURE	andell			-1-0	,	,				0 3		

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ages 1, 2, 3 should

FUNERAL DIRECTOR

BY

COMPLETED

BE

2

BY PHYSICIAN: MEDICAL CERTIFICATION

BE COMPLETED

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END NOT THE AMERICAN. THE AMERICAN CONTROL OF THE CONTROL OF THE CONTROL OF THE HOSPITAL OF THE MENT O	The complete of the transform has been upped by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. P		"If them 28 is marked, or them 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
cuted within 24 hours after d	d completely filled in by the	Tours after every will the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ic event, the medical e
the death certificate be exec	the attending physician and	I Mental Hygiene prior to b	injury, or other traumal
W: The law requires that the	ficate has been signed by	State Dept. of Health and	r item 23 shows any i
USOR ATTENDING PHYSICU	(ADPRECTOR: After this cent	Phours after death with the	f Item 28 is marked, or
Œ.	œ.	3	

FOR STATE REGISTRAR		STATE OF M	ARYL	AND / I	DEPAR	TMENT	OF H	EALTH AI	ND N		YGIEN EG. NO.	E .	93	09748	
1. OECEDENT'S NAME (First,	Middle, Last)									2. DATE OF D	EATH DA	w	YEAR	3. TIME OF DEATH	
ISABEL	С.	,	PH]	LLIP	S					MARCH	-	••	1993	5:05 A M	
4. SOCIAL SECURITY NUMB					AGE (In yrs. last birthday)			IF UNDER 24 H	HRS.	7. DATE OF BIRTH (Month, Day, Year)			8. BIRTI	IPLACE (State or Foreign	
216-40-6906		1 🗆 M 2 💢 F	81	1	YRS.	MONTHS	DAYS	noons a		Sept 2	21, 1	1911		Ohio	
Sa. FACILITY NAME (If not in	stitution, give s	treet and number)				9b. CITY, T	OWN C	R LOCATION	OF DE	ATH		9c. COU	NTY OF E	EATH	
6207 East H	albert	Road				Bet	he	sda				Mor	ntgor	nery	
10a. STATE	10b. COUNTY				10c. CITY	, TOWN OR	LOCAT	ION						10d. INSIDE CITY	
Maryland	Mont	gomery			Bet	hesda	1							LIMITS? 1 YES 2 NO	
IO. STREET AND NUMBER							_	. ZIP CODE				10g. CIT	IZEN OF Y	WHAT COUNTRY?	
6207 East Halbert Road								20817				Uni	ited	States	
11. MARITAL STATUS		12. WAS DECEDENT	EVER I	N U.S. ARM	EO	13. W	S DEC	ENDENT OF H	IISPANI	C ORIGIN? (Sp	ecify Yes		14, RAC	E — American Indian.	
1 Never Married 2		FORCES? 1			)			ecify Cuben, N 2 NO 3		an, Puerto Rican, etc.) Bl				ecity:	
3 Widowed 4 Divo														White	
	EDENT'S EDU highest grade			(Give	kind of w	USUAL OCC		on st of working		16b. KJM	D OF BUS	INESS/IN	DUSTRY		
Elementary/Secondary (0	-12)	College (1-4 or 5 +)		life. Do NOT use retired.)											
		5+		Chi	ld T	heran				Clinical Social Work				Work	
17. FATHER'S NAME (First, Mi	iddle, Last)	0.1							-	AME (First, Middle, Maiden Surname)					
Morris	-	Col	חו					Fann			:		vcke	<u> </u>	
19a. INFORMANT'S NAME (7)								nd Number or I	Rurel A	oute Number, C	ity or Town	n, State, Zi	Code)		
Paul S. Phi		(Husband	<u>(t</u>	S	ame	as #1	0								
20a. METHOD OF DISPOSITI		oval from Stata				F DISPOSITI				OATE 20c. LOCATION — City					
4 Donation 5 Other			3	Subur	bán	Crema				3–19	_Si.	Lver	Spr	ing, MD	
21. SIGNATURE OF FUNERAL	L SERVICE LIC	CENSEE						D ADDRESS			20 [	ο Λ			
D.Oll	-13.	Plat		MO	0827			unera ist Av					MD	20910	
	eart failure.	complications that List only one caus	cause e on e	d the deat		ot enter th	ne mo	de of dying,	, such	an cardiac	or respi	ratory ar	rest,	Approximate Interval Between	
iMMEDIATE CAUSE (Fin						0								Onset and Death	
resulting in death)	<b>→</b>	. MYOC	OR AS	CONSEDE	ENCE OF	tarc'	tio	<u> </u>						minutes	
Sequentially list conditi if any, leading to immed	aidle.	atheros DUE TO	C IE F	CONSECU	VAS	cular	di	Jene				<u> </u>		years years	
cause. Enter UNDERLYI CAUSE (Disease or inju that initiated events resulting in death) LAS	ry	c. Smok:	ng or As A	CONSEQU	I h	yper	ten	sin						years	
resulting in death) LAS		4													

disease or condition \_\_\_\_\_\_resulting in death) Sequentially list condition if any, leading to immediate. Enter UNDERLYI CAUSE (Disease or injur that initiated events resulting in death) LAS PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a, WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS **AMAILABLE PRIOR TO** Chronic obstructive pulmonary disease COMPLETION OF CAUSE OF DEATH? 1 - YES 2 XNO 1 YES 2 NO

	RRED TO MEDICAL		26. PLACE OF DEATH (Check only one)									
EXAMINER?	NO	HOSPITAL: 1   Inpatient 2   ER/Outpatient :		1ER: Nursing Home 5 X Residence	8 Other (Specify)							
MANNER OF DEA	TH 5 Pending Investigation	26a. DATE OF INJURY (Month, Day; Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?  1 YES 2 ND	28d. GEŞCRIBE HOW INJURY OCCURED							
3 Sulcide	8 Could not be	28e. PLACE OF INJURY Al he building, atc. (Specify)	ome, ferm, street,	factory, offica	281. LOCATION (Street and Number or Rural Route Number,							

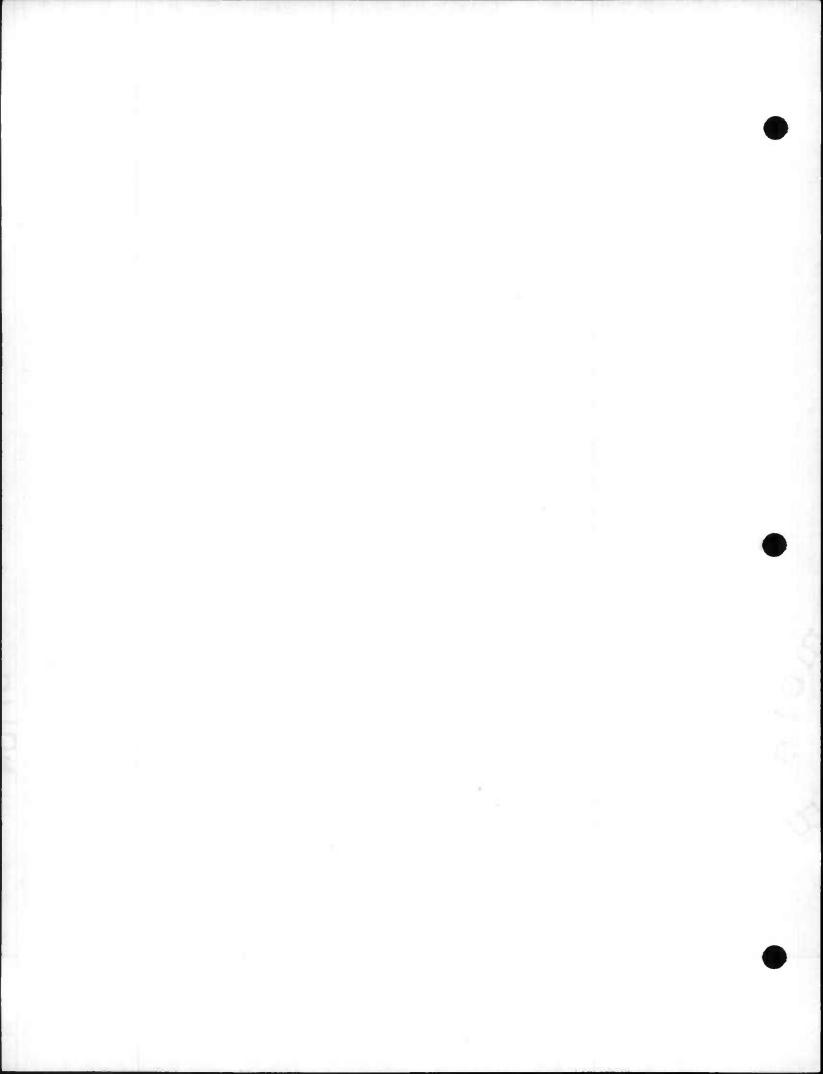
29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To like best of my knowledge, death occurred at the ilme, data and place, and due to the cause(a) and manner as stated.

2 MEDICAL EXAMINER: On the	basis of examination and/or im	reatigation, in my opinior	i, death occured at the ilme,	data and place, and	due to the cause(a) and m	enner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Barby Slarled in 10.	026900	March 19, 1993

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Barbara Blaylock, M.D. 6111 Executive Blvd, Rockville, MD 20852 31. DATE FILED (Mornin, Day, Year)
WAR 22 93 32. AFGISTRAR'S SIGNATURE Pandall

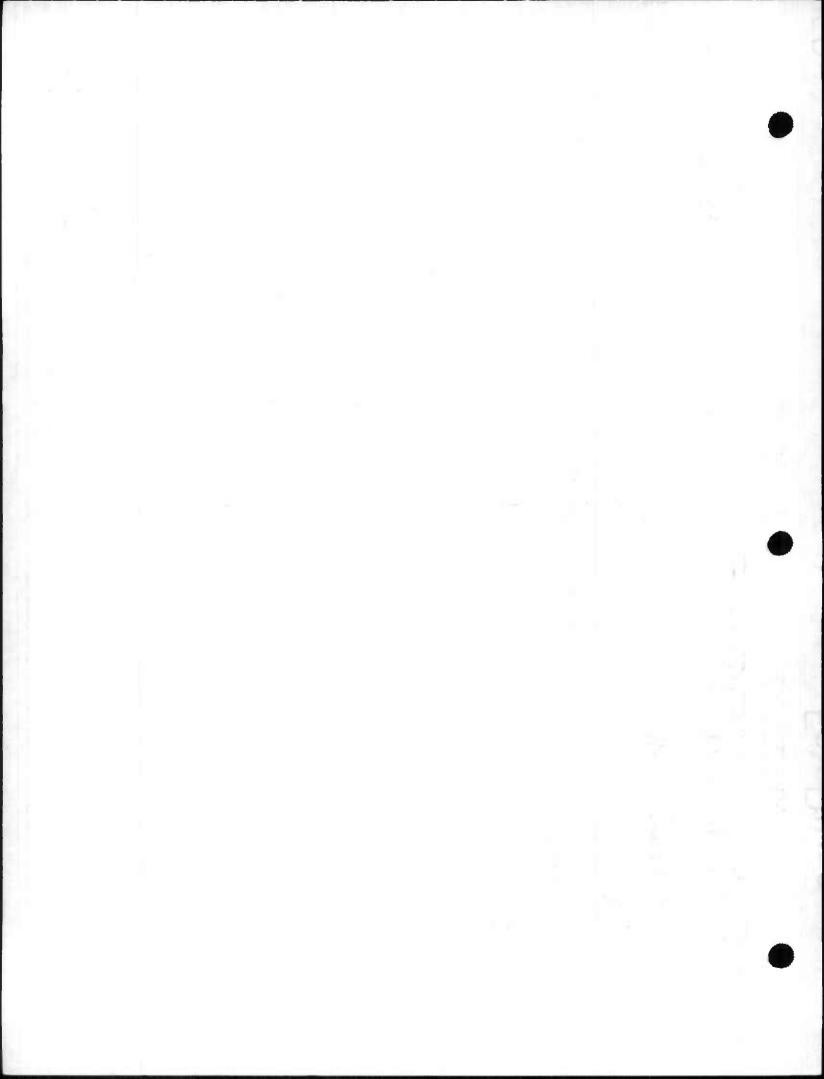


A ATTENDING PHYSICIAN: The Jaw requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician.	Different. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be detached for use as the bunial-transit permit.	americal, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
NG PHYSICIAN: The law requires that the death	ther this certificate has been signed by the atten- tath with the State Dept. of Health and Mental H	marked, or item 23 shows any injury, or
ON ATTEND	DIRECTOR: J	Sem 28

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

- 1	1. DECEDENT'S NAME (First, Middle, Lest)  2. DATE OF DEATH MONTH DAY YEAR  3. TIME OF DEATN												3. TIME OF DEATN		
1	Anna Elizab			March 19, 1993 21:05											
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs. la:	st birthday)	IF UNDER 1 Y	$\rightarrow$	IF UNDER	MIN.		TE OF BIRTH		6. BIRTH	IPLACE (State or Foreign	
	577-26-5402		1 🗆 M 2 🔀 F	93	YRS.	MONTAS D	ATS	HOURS	mire.		ch 18,	1900		**	
	9e, FACILITY NAME (If not in	stitution, give s	treet and number)			9b. CITY, TO	OWN OF	R LOCATI	ON OF D	DEATN		9c. COU	NTY OF D	EATH	
DIRECTOR	Wilson Heal		Gaitl	ner	sbur	g_			Mon	tgom	ery				
REC	10a. STATE 10b. COUNTY					Y, TOWN OR	LOCATI	ON						10d. INSIDE CITY LIMITS?	
₫	Maryland Montgomery					thers	our	g						1 TYES 2 1 NO	
AL	10e. STREET AND NUMBER						10f.	ZIP COD	E			10g. CITI	ZEN OF Y	WHAT COUNTRY?	
띹	18620 Walke	r's Ch					20	0879				U.S	.A.		
FUNERAL	11. MARITAL STATUS 1 Never Married 2	Administration of the Control of the	12. WAS DECEDED FORCES?	T EVER IN U.S. AI	RMED NO						GIN? (Specify Yes to Rican, etc.)	or No-	14. RACE Black	E — American Indian, k, White, atc.	
BY	3 Widowed 4 Divo			MAR OR DATES				2 X NO					Speci	My: White	
	Λ	EDENT'S EDU	CATION	16a Di	CEDENT'S	USUAL OCCI	IPATIO	N	_	1	16b, KIND OF BU	SINESS/INT	HISTOV	wurte	
COMPLETED	(Specify onl	y highest grade	completed)	(0		work done dun			ng		TOU, KIND OF BU	SHIESS/HIE	/03/K1		
P	Elementary/Secondary (I	1-12)	College (1-4 or 5	1	ne Ma	kor					Own Hon	••			
OM	17. FATHER'S NAME (First, M	liddle, Last)			ic ria	KCI		18. MOT	NER'S N		st, Middle, Maiden		_		
O	John Cadwal	lader						Ann	a B	. Li	neburg				
BE	19a. INFORMANT'S NAME (	Type/Print)		15	b. MAILING	ADDRESS (S	treet an				umber, City or Tow	n, State, Zip	Code)	20879	
5	Ruth P. Har	tley			8620	Walke	er's	s Ch	oic	e Rd	. Apt.	5 Ga	ithe	rsburg, MD	
	20a. METHOD OF DISPOSIT			20b. PLACE	AND DAT	E OF DISPOS	ITION (				ATE 20c. LO				
	1 X Buriel 2 Cremetic 4 Donation 5 Other		oval from State	- Green	Hi1	or other place 1 Ceme	e) etei	rv		3	/23, Ste	phens	Cit	V. VA	
	21. SIGNATURE OF FUNERA	L SERVICE LIC	CENSER			22. NA	ME AN	D ADDRE	SS OF F	ACILITY			V	2) 1	
- 3	> >.5	: 15	1					Fu					hersburg, MD 20877		
	23 PART I Enter the	Iseases pr	complications the	et coused the d	eath Do										
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate interval Between												interval Between		
	IMMEDIATE CAUSE (Fine)										Onset and Deeth				
	diseese or condition													_	
	disease or condition resulting in death)	<b>→</b>		opneumo		NE-								1 week	
		<b>+</b>		OPNEUMO		PF):								_	
NOI	resulting in death)  Sequentially list condit		DUE TO		OUENCE O									_	
CATION	resulting in death)  Sequentially list condit if eny, leading to imme cause. Enter UNDERLY	diate iNG	DUE TO	OR AS A CONSE	OUENCE O									_	
IFICATION	Sequentially list condit if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or Inji that initiated events	diate iNG ury	b. DUE TO	OR AS A CONSE	OUENCE O	PF):								_	
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CAL CERTIFICATION	Sequentially list conditions if eny, leading to imme cause. Enter UNDERLY CAUSE (Disease or Injusted Initiated events resulting in death) LAS	ent condition	DUE TO DUE TO DUE TO d	O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE	OUENCE O	PF):		j ceuse	given i	n Part I.	PERFO	RMED?	24b	1 week	
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MEDICAL CERTIFICATION	Sequentially list conditions if eny, leading to imme cause. Enter UNDERLY CAUSE (Disease or Injusted Initiated events resulting in death) LAS	ent condition	DUE TO DUE TO DUE TO d	O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE	OUENCE O	PF):		J couse	given i	n Part I.	PERFO	RMED?	245	1 Week  WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE	
_	Sequentially list condit if eny, leading to imme cause. Enter UNDERLY CAUSE (Disease or Injusted initiated events resulting in death) LASPART II. Other significations and the cause of the	ent condition	DUE TO DUE TO DUE TO d	O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE	OUENCE O	PF):					PERFO	RMED?	24b	1 Week  WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
_	Sequentially list condit if emy, leading to imme cause. Enter UNDERLY CAUSE (Disease or injuted initiated events resulting in death) LASPART II. Other signific.  Alzheimers  25. WAS CASE REFERRED TEXAMINER?	ent condition	DUE TO  DUE TO  DUE TO  d.  ac contributing to  ase with	O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O death but not profoun	OUENCE O	in the under	26. PL	ACE OF I	DEATH (C	Check only	PERFOI	RMED?	24b	1 Week  WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
_	Sequentially list condit if eny, leading to imme cause. Enter UNDERLY CAUSE (Disease or Inject that initiated events resulting in death) LAS PART II. Other aignific.  Alzheimers  25. WAS CASE REFERRED 12	ent condition	DUE TO  DUE TO  DUE TO  DUE TO  DUE TO  DUE TO  DUE TO  HOSPITAL:  1   Inpatient 2	O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O death but not profoun	OUENCE O	ornentia	26. PL	ACE OF I	DEATH (C	Check only	PERFOI  1 YES :	RMED?		1 Week  WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
PHYSICIAN:	Sequentially list condit if eny, leading to imme cause. Enter UNDERLY CAUSE (Disease or injuthed initiated events resulting in death) LASPART II. Other signific.  Alzheimers  25. WAS CASE REFERRED 1 EXAMINER?  1 YES 2 NO  27. MANNER OF DEATN	ent condition disea	DUE TO  DUE TO  DUE TO  DUE TO  DUE TO  Ase with  HOSPITAL: 1   Inpatient 2	O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O death but not profoun	OUENCE O	ornentia	26. PL. g Nome Bc. INJU WOI	ACE OF I	DEATH (C	Check only	PERFOI	RMED?		1 Week  WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
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BY PHYSICIAN:	Sequentially list conditions, leading to immediate. Enter UNDERLY CAUSE (Disease or Injured in the initiated events resulting in death) LASPART II. Other aignifications and the sequence of t	ent condition disea	DUE TO  b. DUE TO  c. DUE TO  d	O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O death but not profoun  ER/Outpatient FINJURY	OUENCE O	ornentia	26. PL. g Nome Bc. INJU WOI 1  Y	ACE OF 1  5 G R  URY AT RK?  (ES 2	DEATH (C	Check only  6 0 0  28d.	PERFOI  1 YES :	RMED?  NO  NO  NO  NO  NO  NO  NO  NO  NO  N	CURED	1 Week  Were autopsy findings Mailable prior to completion of cause of death?  1 Yes 2 No	
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COMPLETED BY PHYSICIAN:	resulting in death)  Sequentially list condit if eny, leading to imme cause. Enter UNDERLY CAUSE (Disease or Injuthet initiated events resulting in death) LAS  PART II. Other aignific:  Alzheimers  25. WAS CASE REFERRED 1 EXAMINER?  1 YES 2 X NO  27. MANNER OF DEATN 1 X Netural 5 2 Accident 3 Suicide 6 4 Homicide  29a. CERTIFIER (Check only 1 X CER	ent condition  disea  o MEDICAL  Pending Investigation Could not be determined  TIFYING PHYS DICAL EXAMINE  FOR CENTREE	DUE TO  b. DUE TO  c. DUE TO  d	O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE O (OR AS A CONSE	OUENCE O	OTHER: 4 XNursin ME OF 20 Street, factor	26. PL. g Nome Be. INJI WOI 1  Y office	ACE OF 1  5  R  URY AT  RK?  YES 2    and place eath occur  29c. LKC	DEATH (Clasidence NO e, and do	28d. 28d. 28d. Course to the time, course to the course to	PERFOLITION (Specify)  DESCRIBE HOW  COCATION (Street Cause(a) and ma	and Number of the state of the	r or Rural .  Ited .  the cause(	A Week  Were Autopsy Findings AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  Route Number,  (a) and manner as stated.	
BE COMPLETED BY PHYSICIAN:	resulting in death)  Sequentially list condit if eny, leading to imme cause. Enter UNDERLY CAUSE (Disease or Injit that initiated events resulting in death) LAS  PART II. Other aignifice.  Alzheimers  25. WAS CASE REFERRED 1 EXAMINER?  1 VES 2 NO  27. MANNER OF DEATN  1 Netural 5 CERTIFIER (Check only one) 2 MED  29b. SMSNATURE AND TITLE  29b. SMSNATURE AND TITLE	ent condition  disea  To MEDICAL  Pending Investigation Could not be determined  TIFYING PHYS DICAL EXAMINE  E OF CENTREE	DUE TO  b. DUE TO  c. DUE TO  d	O (OR AS A CONSE O (OR	OUENCE O	OTHER: 4 XNursin ME OF JURY M street, factory	26. PL. g Nome Be. INJI WOI 1  Y office	ACE OF 1  5  R  URY AT  RK?  YES 2    and place eath occur  29c. LKC	DEATH (Contestion of the contestion . 28d. 28d. Course to the time, course to the course to	PERFOLITION (Specify)  DESCRIBE HOW  COCATION (Street Cause(a) and ma	and Number of the state of the	r or Rural .  Ited .  the cause(	1 Week  Were Autopsy Findings MALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  Route Number,		
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BE COMPLETED BY PHYSICIAN:	resulting in death)  Sequentially list condit if eny, leading to imme cause. Enter UNDERLY CAUSE (Disease or Injit that initiated events resulting in death) LAS  PART II. Other aignifice.  Alzheimers  25. WAS CASE REFERRED 1 EXAMINER?  1 VES 2 NO  27. MANNER OF DEATN  1 Netural 5 CERTIFIER (Check only one) 2 MED  29b. SMSNATURE AND TITLE  29b. SMSNATURE AND TITLE	ent condition  of disease  of MEDICAL  Pending investigation  Could not be detarmined  of CENTAGE  FERSON WHOORE, J	DUE TO  b. DUE TO  c. DUE TO  d	O (OR AS A CONSE O (OR	OUENCE OF THE PROPERTY OF THE	OTHER: 4 XNursin ME OF JURY M street, factor	g Nommer grant gra	and place eath occu	DEATH (Classidence No No No No No No No No No No No No No	28d. L 28d. L 28d. L 28d. L UMBER	PERFOLITION (Specify)  DESCRIBE HOW  OCATION (Street Zity or Town, State  cause(a) and madata and place, as	and Number and stand due to t	r or Rural .  Inted.  The cause(  TE SIGNED	A Week  Were Autopsy Findings AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  Route Number,  (a) and manner as stated.	



VSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending ohrsician.	this certificate has been signed by the attending physician and completely filled in by the funeral director pane 5 should be detached for use as the huristanese narms in page 4.9.2 about	ith the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ed, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HISPITAL OF AMENDING PHYSICIAN: The law requires that	TO THE RIVER LIDITIONS. After this certificate has been signed	be filed with 72 hours with death with the State Dept. of Health a	IMPORTARY It then 28 Is marked, or item 23 shows any

,d3

PANUAI

MAR

	1 - FOR STATE REGISTRAR	STATE OF MAR	RYLAND /	DEPART ERTIFIC	MENT (	OF HE	ALTH AND DEATH	MENTA	AL HYGIEN REG. NO		93	09750
	1. DECEDENT'S NAME (First, Middle, Last)	RUBI	NSTE	EIN.				2. DATE OF DEATH MONTH S 16 93 10:30				
	4. SOCIAL SECURITY NUMBER 577-48-0783	5. SEX 6. /	AGE (In yrs. lesi	t birthday)	IF UNDER 1 Y		IF UNDER 24 HRS. HOURS MIN.	7. DATE (Mon	E OF BIRTH oth, Day, Year)	1907	Country	PLACE (State or Foreign
TOR	9a. FACILITY NAME (If not institution, give s  HEBREW HOME OF GI RESIDENCE OF DECEDENT		HINGTO				VILLE			9c. COU	NTGOM	ATH
DIRECTOR	10a. STATE 10b. COUNTY	ONTGOMERY	GOMERY ROCKVILLE								10d. INSIDE CITY LIMITS? 1 XYES 2 NO	
FUNERAL	100. STREET AND NUMBER  101. ZIP CODE  102. CITIZEN OF WH  103. CITIZEN OF WH  104. ZIP CODE  105. CITIZEN OF WH											
ΒY	11. MARITAL STATUS  1 Never Merried 2 Married  3 Widowed 4 Divorced	12. WAS DECEDENT EV FORCES? 1 1 1 IF YES, GIVE WAR (		MED IO	lf y	S DECEN res, speci	IDENT OF HISPA	ANIC ORIGI	IN? (Specify Ye Rican, stc.)		14. RACE	STATES  American Indian, Whita, atc.
COMPLETED	15. DECEDENT'S EDUI (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	(Gh	CEDENT'S US We kind of wor Do NOT use	rk done duri retired.)	UPATION ring most	of working	16	b. KIND OF BU	SINESS/INI		WHILE
BE COM	17. FATNER'S NAME (First, Middle, Last) SOLOMAN RUBINSTE	<u>I</u> N					BESS	E B	Middle, Maiden	Surname)		
2	19a, INFORMANT'S NAME (Type/Print)  MELVIN SIEGEL						Number or Rural					MD. 20901
	20a. METNOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. PLACE AND DATE OF DISPOSITION (Name of XING DAVID MAUSOLEUM  20c. LOCATION — City or Town, State 3/18 FALLS CHURCH, VIRGINIA											
	21. SIGNATURE OF FUNERAL SERVICE LIC	Stm	e		DANZ	ZANS	ADDRESS OF FACE OLD	BERG				LS, INC
	23. PART i. Enter the diseasea, or c shock, pr heart failure. I IMMEDIATE CAUSE (Finel disease or condition resulting in death)	omplications that certains only one cause of the control of the co	n each lina.		t enter th	a mode	of dylng, su	ch aa car	diac or reap	Iratory ar	reat,	Approximata interval Batween Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury		AS A CONSEO									
ERTI	that initieted events resulting in deeth) LAST	l,		OLNOE OF J.								
PHYSICIAN: MEDICAL	PART II. Other eignificent conditions  DEMENT  CHRON(C	A		PERI					RMED? AVAILABLE P			
IAN: N	25. WAS CASE REFERRED TO MEDICAL						E OF DEATH (C)					YES 2 NO
YSIC	EXAMINER?	HOSPITAL:	-		THER:		5 Rasidence					
ВУ РН	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJU (Month, Day, Ye	er)	28b. TIME (	M 1			28d. DE	SCRIBE NOW I	NJURY OC	CURED	
8	3 Suicide 8 Could not be determined	28a. PLACE OF INJ building, atc. (	URY — At hom Specify)	ne, farm, stre	et, factory,	, offica		281. LOC City	CATION (Street a or Town, State)	and Number	or Rural Ro	ute Number,
COMPLET	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER	CIAN: To the best of my k	nowledge, das	th occurred a	at the time.	, data and	d place, and due	to the car	use(s) and mar a and placa, an	ner as stat	led. ne cause(s) :	and menner as stated.
BEC	296. SIGNATURE AND TITLE OF CERTIFIER	1 M.D				25	C. LICENSE NU					Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO	-					D36	775		2	5/16	193

M.D. 36552 16/93 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RD. POCKVILLE MONTROSE Mp. 20852 6121 32. REGISTRAR'S SIGNATURE

MONTGOMERY CO.

10g. CITIZEN OF WHAT COUNTRY? U.S.A.

3. TIME OF DEATN

8. BIRTNPLACE (State or Foreign

10d. INSIDE CITY LIMITS? 1 YES 2 NO

> Approximate Interval Betwe Onset and Death

24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?

1 YES 2 NO

and due to the cause(s) and manner as stated. 29d. DATE SIGNED (Morth 994

14. RACE — American Indian, Black, White, atc. Specify: WHITE

2:20P M

REG. NO.

2. DATE OF DEATH MONTH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

31. DATE FILED (Month, Day, Year)
MAR 23 93

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	William Rawson VEAR 03 11 1993																	
	4. SOCIAL SECURITY NUM		5. SEX	6. AGE (In yrs. I		IF UNDER 1 Y		HRS. 7. DAT	E OF BIRTN onth., Day, Year)	8.	BIRTNPLACE (State							
	362-12-2900 19 /6 YRS. 02/.6/17 1										Country) UTAH							
TOR	NATIONAL RESIDENCE OF DE	LUTH		1E			OCKVIL			9c. COUNTY	OF DEATH							
DIRECTOR	10a, STATE MD •	10b. COUNT	Y NTGOMERY	d co.		TOWN OR L					10d. INSIDE LIMITST							
FUNERAL	10e. STREET AND NUMBER 9505-		RS DRIVE	E			101. ZIP CODE	0850			OF WHAT COUNTE							
B∀	11. MARITAL STATUS 1 Never Merried () 3 Widowed 4 Div		12. WAS DECEDENT FORCES? X IF YES, GIVE W	XYES 2 AR OR OATES		17 ye	DECENDENT OF s, specify Cuben, YES 25 XNO	HISPANIC ORIG Mexican, Puert Specify:	GIN? (Specify Yes o Rican, etc.)	or No- 14.	RACE — American Black, White, atc. Specify: WHI							
APLETED	15. DEI (Specify on Elementary/Secondary (	CEDENT'S EDU ly highest grade 0-12)	CATION completed) College (1-4 or 5 +		ECEDENT'S U Give kind of wo le. Do NOT use	vk done durin	PATION g most of working	1	BE. KIND OF BU	SURAN(								
E COMPL	17. FATHER'S NAME (First, A WILLIA		RAWSON						, Middle, Maiden KNUD									
TO B	190. INFORMANT'S NAME (	,,	AWSON	1	9505-	VEI	reet and Number or RS DRI	Rural Route Nu.	mber, City or Tow	n, Stete, Zip Coo	20850							
	20a. METNOD OF DISPOSIT 1 X Burlal 2 Cremetic 4 Donation 6 Other	on 3 🗆 Ram	oval from Stata	cemetery, ca	AND DATE OF	er placel		1.		CATION — City								
	PROVÓ CÉMETERM 3/15 PROVO, UTAH  21. SIGNATURE OF FUNERAL SERVICE LICENSEE  PROVÓ CÉMETERM 3/15 PROVO, UTAH  22. NAME AND ADDRESS OF FACILITY HYSONG COMPANY 1300- N ST., N.W., WASH., DC																	
CERTIFICATION	IMMEDIATE CAUSE (Fit disease or condition resulting in death)  Sequentially list condit if sny, leading to imme cause. Enter UNDERLY CAUSE (Disease or injected initiated events resulting in death) LAS	elons, dilata ING	DUE TO (	OR AS A CONSE	OUENCE OF):	of na	Chr	for	st ilu- fec	e Kror	Appro Intervi Onset							
IN: MEDICAL	PART II. Other signification	Sh	Contributing to a	Pac	resulting in	the under	ying cause give	agl in Part I.	24s. WAS AN PERFOR	MED?	24b. WERE AUTOP: AWAILABLE PR COMPLETION OF DEATH? 1 YES 2							
SICIAN:	25. WAS CASE REFERRED T EXAMINER? 1 YES 2 X NO	O MEDICAL	HOSPITAL:	FR/Outnetlant		THER:	B. PLACE OF DEAT											
ВУ РНУ		Pending Inveatigation	28a. OATE OF II (Month, De)	NJURY	28b. TIME	A The state of the			6 Unither (Specify)  28d. OEŞCRIBE HOW INJURY OCCUREO									
<b>a</b>		Could not be detarmined	28a. PLACE OF building, a	INJURY — At hete. (Specify)	ome, ferm, str	na, farm, streat, factory, offica  261. LOCATION (Street and Number or Rural Route Num City or Town, State)												
OMPLET	29a. CERTIFIER (Check only one) 1 💢 CERTI 2 MED	TEYING PHYSI	CIAN: To the best of n	ny knowledge, d	eath occurred	at the time,	date and place, an	d due to the cr	luse(s) and men	ner as atated.	(26/8) and manner							
E CO				1	1	(Check only 1 XX CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and memor as stated.												

DR. CHARLES KARESH- 1 NORTH MAIN STREET, MT. AIRY, MD.

32. REGISTRADES SIGNATURE Pandalle

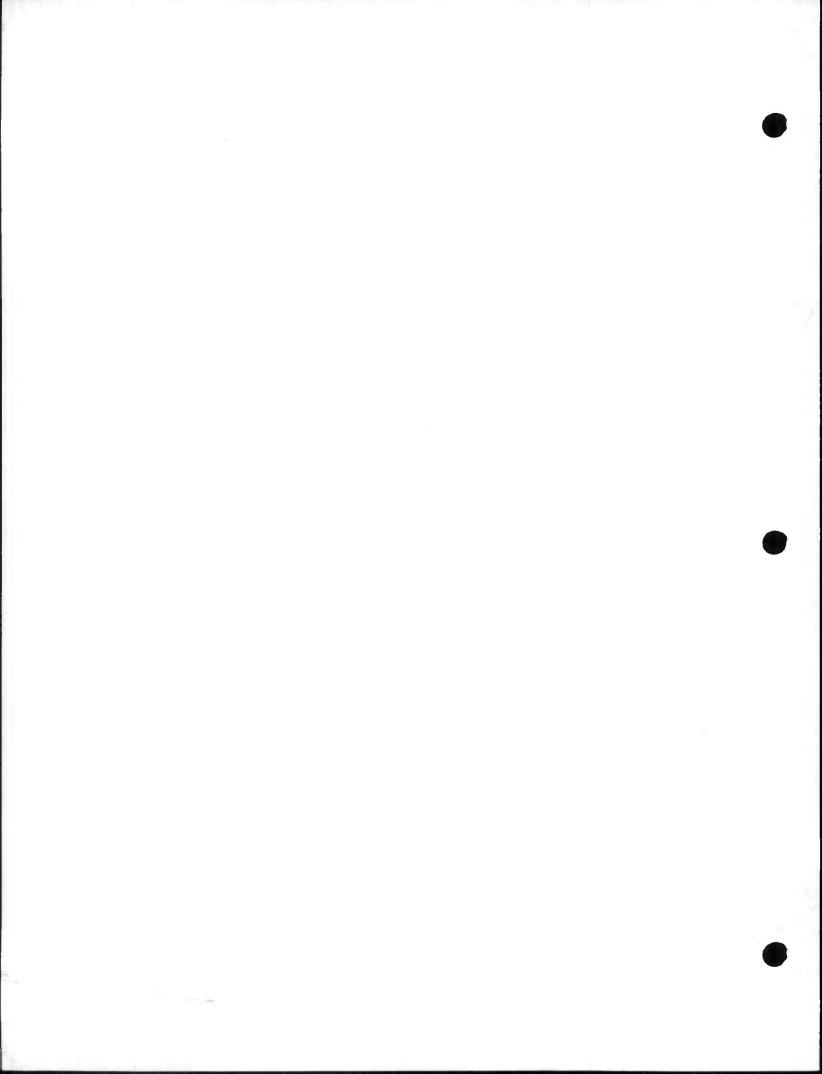
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

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		FOR STATE REGISTRAR	MENTAL HYGIE	REG. NO.						
	8	1. DECEDENT'S NAME (First, Middle, Lange  4. SOCIAL SECURITY NUMBER	posonula	I. RING(		· · · · · · · · · · · · · · · · · · ·	Mar. 9,	1993	3. TIME OF DEATH  0340  A	
3 should	3	184-07-0353  9a. FACILITY NAME (If not institution, give	130 M 2 🗆 F	76 YRS.	MONTHS DAYS  9b. CITY, TOWN	IF UNDER 24 HRS. HOURS MIN. OR LOCATION OF D	7. DATE OF BIRTH (Month, Day, Year) 04-18-19		BRITHPLACE (State or Foreign Country) Pennsylvani	
1. 2.	DIRECTOR	Holy Cross Ho	spital			r Sprin			NTGOMERY	
permit. Pages		Maryland No. STREET AND NUMBER	Montgomery	10c. CIT		rsburg			10d. INSIDE CITY LIMITS? 1 YES 2 M NO	
ian. -transit	FUNERAL	10303 Watkins	Mill Drive	III C ADMICD		208		ט	.S.A.	
우를	BY	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	If yes, at		NIC ORIGIN? (Specify Warn, Puerto Rican, etc.) y:	- 5	RACE — American Indian, Black, White, etc. Specify: Black	
	LETED	15. DECEDENT'S EDU (Specify only highest gradi Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	life. Do NOT us	rork done during mi e retired.)	ON ost of working		usiness/indust		
RYLAND 3 ed by the hospital uld be detached fe ed at once.	COMPL	17. FATHER'S NAME (First, Middle, Last)	2 yrs.	Carr	enter		ME (First, Middle, Melde		yea	
MA retain 5 sho	TO BE	Arthur Ringgol  19a. IHFORMANT'S NAME (Type/Print)  Judith R. Doco		19b. MAILING	ADDRESS (Street			wn, State, Zip Coo Gaithe	*) 20879 rsburg, MD	
ORE, 6 may be ctor, page		20a. METHOD OF DISPOSITION  1  Burial XIXCremation 3  Ren 4  Donation 5  Other (Specify)	20b.	. PLACE AND DATE (	F DISPOSITION (N	eme of Cremato	DATE 20c. L	ocation - city Alexan	or Town, State	
SALTIN death. Pag e funeral dia al. examiner		21. SIGNATURE OF EMMERAL BERVICE LI	- Drown	len	SNOV	ND ADDRESS OF FA	VERAL HO	ME, P.		
O. BOX 68760,  B. Serificate be executed within 24 hours after ling physician and completely filled in by the righere prior to burlal, cremation, or removal other traumatic event, the medical	: MEDICAL CERTIFICATION	23. PART I. Enter the diseases, or shock, or heart failure.  IMMEDIATE CAUSE (Finel disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	Pneu a. Alzh Pue Tough as a	monia	demer Munu Incer	ntia	th as cardiac or res	Aratory arrest,	Approximata Interval Between Onset and Death 22 WKS  Years YEARS	
KECOKDS, P.  w requires that the death of the signed by the attend it, of Health and Mental It.  shows any Injury, or		PART II. Other significant condition	d	ut not resulting i	n the undarlyin	g cause given in		PRMED?	24b. WERE AUTOPSY FINDINGS ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO	
AN: The law inficate has be state Dept.	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMIHER? 1 ☐ YES 2 ☑ HO	HOSPITAL:	atlent 3 DOA	OTHER:	LACE OF DEATH (Ch	8 Other (Specify)			
NG PHYSICIAN: frer this certifical auth with the St marked, or It	ву РНУ	27. MANNER OF DEATH  1 Hetural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIMI	OF 28c, IN.	JURY AT DRK? YES 2 NO	28d. DESCRIBE HOW	INJURY OCCURE	:D	
TTENDI TTENDI TTOR: A after d	ETED 8	3 Suicide 8 Could not be 4 Homicide datermined	28e. PLACE OF IHJURY building, etc. (Spec	— At home, farm, s	treet, factory, offic	, factory, office  281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
2 3 2	COMPL		ER: On the best of my knowledge.						use(e) and manner as stated.	
TO THE PROSPRY TO THE PUNERS De filed within 7 IMPORTANT:	TO BE	296. SIGNATURE AND TITLE OF CERTIFIE	h mo			29c, LICENSE NUI		29d. DATE SIG	NED (Month, Day, Year)	
		JEANNE P. ASH	ER MD 372	OFARRA	GUT A	VE KE	NSINGTON	JMD	20875	
)		31. DATE FILED (Month, Day, Year) MAR 12 '93	32. REGISTRAR'S SIGH							



permit. Pages 1, 2, 3 should

or attending physician.	THE FOWERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transft		
FROSPILE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	ge 5 should be detached f		e notified at once.
s after death. Page 6 may	by the funeral director, pa	emoval.	PORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
executed within 24 hours	and completely filled in	filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	natic event, the med
the death certificate be	the attending physician	I Mental Hygiene prior to	Injury, or other traur
: The law requires that	cate has been signed by	state Dept. of Health and	Item 23 shows any
ATTENDING PHYSICIAN	ECTOR: After this certific	s after death with the S	1 28 is marked, or
THE HOSPITAL OR	THE FUNERAL OIR	filed within 72 hour	PORTANT: If Item

TO THE PUMERA be filed within 72 IMPORTANT: II

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296. SIGNATURE AND TITLE OF CERTIFIER

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31. DATE FILEO (Month, Day, Year) MAR 16

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30. NAME AND ADORESS OF PERSON WHO COMPLETED CAUSE OF DEATH/(ITEM 27) (Type, Pri

GALLI AN;

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH YEAR Lewis Reinwald 3 13 93 1130 AM 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) - F UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 XW 2 F 277-03-2300 95 Dec. 2, 1897 Alabama 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Washington Adventist Hospital FUNERAL DIRECTOR Takoma Park Montgomery 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Silver Spring Montgomery 1 YES 2 NO 10e. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8505 Springvale Drive 20910 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ▼ YES 2 □ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY 1 TYES 2 NO Specify 3 X Widowed 4 Divorced WW I White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highes Elementary/Secondary (0-12) College (1-4 or 5+) Publishing Company Personnel Director 17. FATHER'S NAME (First Middle Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme, Levis E Reinwald Daisy M. Littleton BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Lewis Reinwald 2207 Richland Street, Silver Spring, MD 20910 20a METHOD OF DISPOSITION
1 ABurtel 2 Cremation 3 Re 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Glen Forest Cemetery 4 Donation 5 Other (Specify) 3-18 Yellow Springs, Ohio 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between **IMMEDIATE CAUSE (Final** Onset and Death disease or condition resulting in death) CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING ALLEN S CLEVEL DUE TO (OR AS A CONSEQUENCE OF): CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS Fi Sillation **AMILABLE PRIOR TO** 3mu chite COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 NO PHYSICIAN: fun Zeona 25. WAS CASE REFERRED TO MEDICA EXAMINER?

1 YES 2 NO 28. PLACE OF OEATH (Ch OTHER: npetient 2 - ER/Outpetient 3 - DOA ng Home 5 - Residence 8 - Other (Specify) 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 X Natural м 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 3 Suicide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be determined 4 Homicide

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner as stated.

0

32 REGISTRAR'S SIGNATURE

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2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner ee stated.

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Dr

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29d. DATE SIGNED (Month, Day, Year)

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BALTIMORE, MARYLAND 21215-0020	death. P	funeral
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permit.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

GEORG

31. DATE FILED (Month, Day, Year)
MAR 22 93

HOSPITAL

gichia Davidson Bandalle

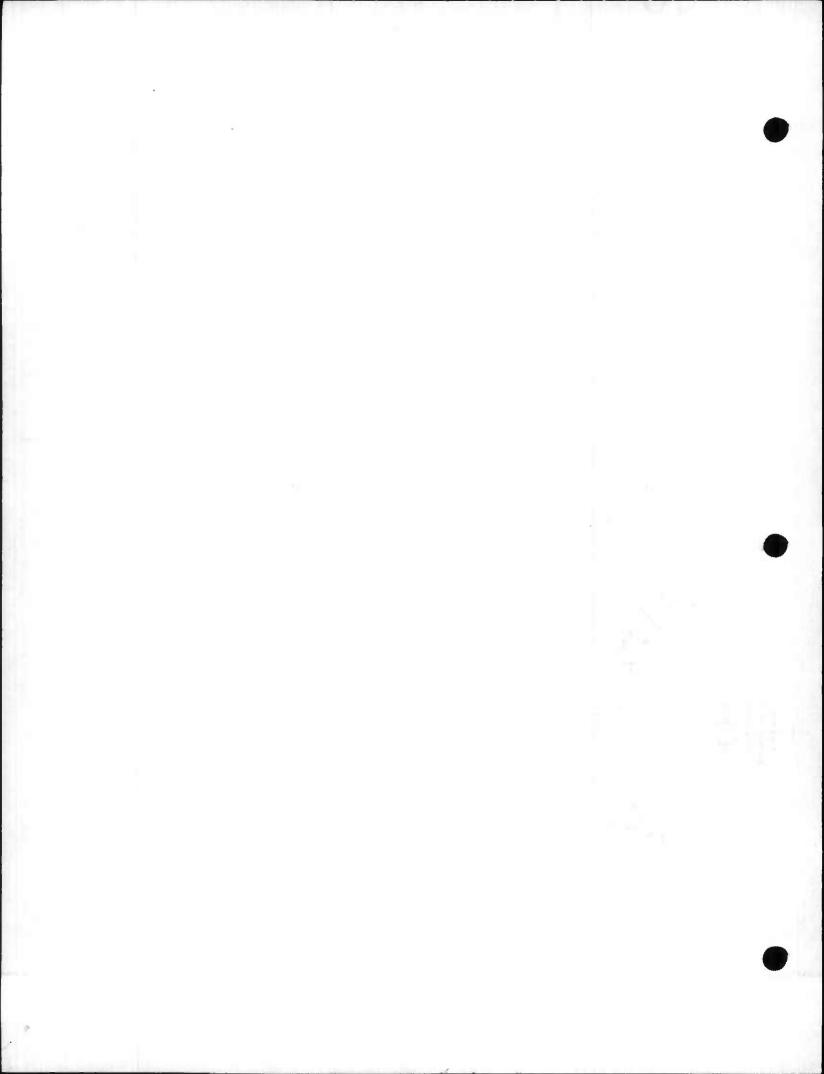
32. REGISTRAR'S SIGNATURE

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY 3. TIME OF DEATH YEAR WILLIAM REESE MARCH 93 8:1050 AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign Country) 1 🖳 M 2 🗆 F HOURS YRS. 067-16-3154 72 March 27. 920New York Sa. FACILITY NAME (If not institution, give etreet and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY RESIDENCE OF DECEDENT 10h COUNTY 10c. CITY, TOWH OR LOCATION 10d. INSIDE CITY Maryland 1- YES 2 NO Prince George Capitol Heights FUNERAL 10e STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 1709 Rollins Place 20743 U. S.A WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 2 YES 2 NO 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexican, Pu 1 Never Married 2 Merried IF YES, GIVE WAR OR DATES BY Specify: Black 3 Widowed 4 Divorced April 4- OCT. 1966 COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16a, DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 American Airlines 4 Foreman of Facility Maint. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) William REESE Daisy Virginia Reed BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Reese 175-15 90th Avenue, Jamaica New York, 11432 DATE 20c. LOCATION -- City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of Baltimore-Washington 3-22-93 Laurel Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22, NAME AND ADDRESS OF FACILITY McGuire Funeral Service, Inc. Honey 7400 Georgia Ave. N.W. 20012 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one ceuse on each line. Approximata interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition SEPSIS resulting in death) DUE TO (OR AS A CONSPOLIENCE OF) ATERAL NEUMONIA CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): RENAL cause. Enter UNDERLYING CAUSE (Disease or Injury QUE TO (OR AS A CONSEQUENCE OF): that initiated events ENCEPHALO PATHY POYIC resulting in death) LAST PART ii. Other aignificant conditions contributing to death but not reaulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE NEUMONIA 1 YES 2 NO OF DEATH? ALCOHOL 1 YES 2 NO DEHYDRATION DIABETES RETO ACIDOSIS PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 The Manusel V 5 Pending Investigation 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) COMPLETED 29a. CERTIFIER
(Chack not)

1. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, 29c. LICENSE NUMBER 0 4 3 3 4 6 29d. DATE SIGNED (Month/Day, Year)

3 / 1 7 / 9 3 BE Dr RITA GUPTA 5. 1. 9 p69 30. NAME AND ANDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

CENTER CHEVERLY



ITEMS: 28a-f, PER MEO G-700 6/18/93 t.t/s.w

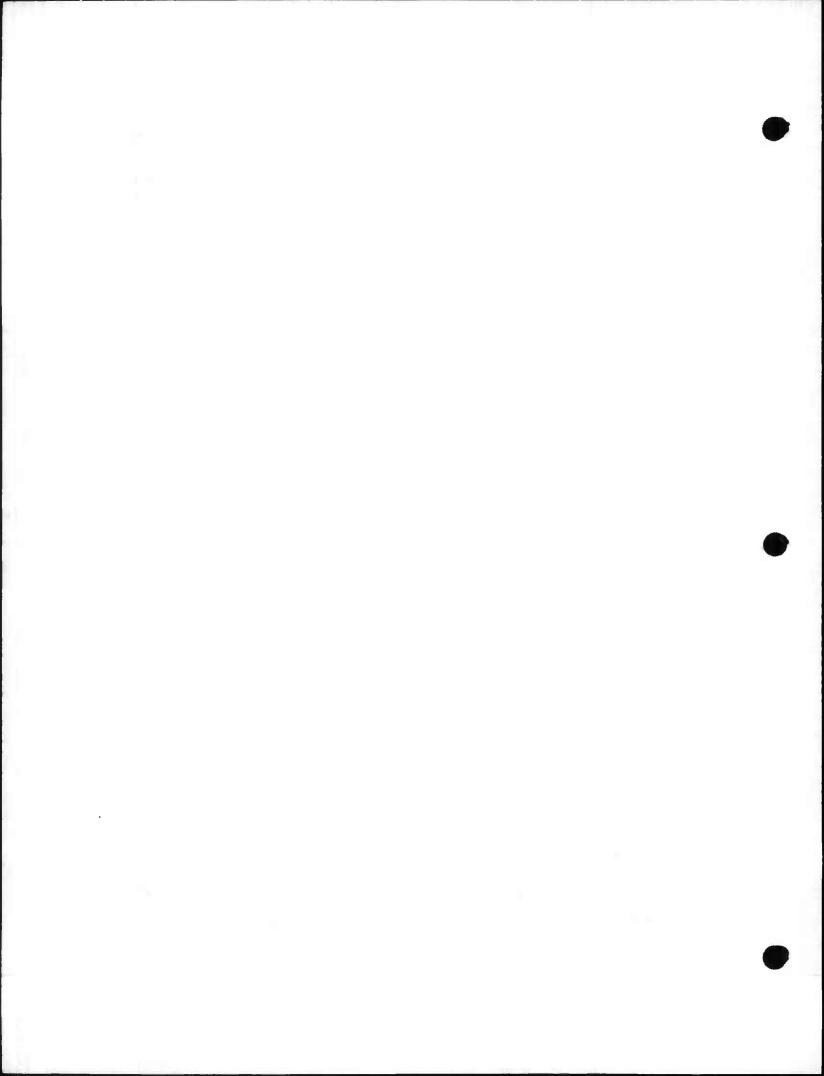
OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

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		1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO.								1755				
		1. DECEDENT'S NAME (Flist, MI	Gold, Last)	ANI	NE	up	per	+		2. DATE MONT	OF DEATH	AYY	EAR 3.	TIME OF DEATH
P		4. SOCIAL SECURITY NUMBER 214-90-0775	1	□ M 2∑□ F	AGE (In yrs. les	YRS.	F UNDER 1	DAYS	IF UNDER 24 HRS. HOURS MIN.	(Mont	OF BIRTH h, Day, Year)	1 M	Country)	
2, 3 should	TOR	9a. FACILITY NAME (If not institu- 19 BRAHMS CO- RESIDENCE OF DECE	URT	t and number)					SPRING	EATH		MONTO		
permit. Pages 1,	DIRECTOR	10a. STATE 10	m. county MONTGO	MERY		10c. CITY,								1. INSIDE CITY LIMITS?  YES 2 NO
n. ansit perm	FUNERAL	100. STREET AND NUMBER 2837 SHEPPER	TON TE	CRRACE				101.	20904			USA	OF WHA	COUNTRY?
Z4 nours after death. Page 6 may be retained by the hospital or attending physician. filled in by the funeral director, page 5 should be detached for use as the burial-transit ion, or removal.	BY FUN	11. MARITAL STATUS 1 Never Married 2 Me 3 Widowed 4 Divorce	rried	P. WAS DECEDENT E FORCES? 1 IT IF YES, GIVE WAR	YES 2	MED 10	11	yes, spe	ENDENT OF HISPAR actly Cuban, Mexica 2X NO Specifi	n, Puerto		s or No- 14	RACE — Black, W Specify:	American Indian, hite, etc.  WHITE
ital or attend of for use as	LETED	(Specify only high Elementary/Secondary (0-12)		ION npleted) College (1-4 or 5+)	(G	CEDENT'S US we kind of wor Do NOT use i	k done dt	CUPATIO iring mos	N st of working	168	. KINO OF BU	SINESS/INDUS	ТЯУ	WILLE
by the hosp be detache at once.	E COMPL	12 17. FATHER'S NAME (First, Middle MICHAEL W.		PT	<u> </u>	URIER			18. MOTHER'S NA		Middle, Maiden			
be retained je 5 should a notified	TO B	194. INFORMANT'S NAME (Types) CHRISTINE A.	/Print)						ON TERRA	Route Num	ber, City or Tox	m, State, Zip Co		20904
ge 6 may be lirector, page r must be		20e. METHOD OF DISPOSITION 1 № Burlel 2 □ Cremetion 4 □ Donation 5 □ Other (Sp	3 Removal		20b. PLACE	AND DATE OF matory or othe OF HEA	DISPOSIT	TION (Nat		3/2	E 20c. LC	CATION — CIT	or Town,	
or death. Pag he funeral di al.		21. SIGNATURE OF FUNERAL SI	, (	Dale	D		FR	ANC	D ADDRESS OF FA IS J. CO NIVERSIT	LLIN				
ted within 24 hours after completely filed in by the ial, cremation, or removal sevent, the medical		23. PART I. Enter the disershock, or hear IMMEDIATE CAUSE (Finat disease or condition resulting in death)	t only one cause	aused the de on each line	N9								Approximate interval Between Onset and Death	
execu n and to bur	ATION	Sequentially tist conditions if any, leading to immediate cause. Enter UNDERLYING	JE TO (OR AS A CONSEQUENCE OF):											
ding phy Hygiene p r other	CERTIFICATION	CAUSE (Disease or Injury that Initiated events resulting In death) LAST	d	DUE TO (OF	AS A CONSEC	QUENCE OF):								
requires that the death een signed by the atter of Health and Mental shows any Injury, c	MEDICAL CE	PART It. Other significant	conditions c	contributing to de	eath but not r	esulting in	the und	lerlying	cause given in	Part I.	24s. WAS AN PERFO	RMED?	CO OF	RE AUTOPSY FINDINGS ILLABLE PRIOR TO MPLETION OF CAUSE DEATH?
> 0 % -		25. WAS CASE REFERRED TO MEDICAL				26. PLACE OF DEATH (Check only			ack only o	1 YES 2 NO		YES 2 NO		
PHYSICIAN: The lanth this certificate has with the State Deprived, or Item 23	PHYSICIAN:	EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH		OSPITAL:   Inpetient 2   ER/Outpetient 3   DOA   4   Nursing Home   Residen			5 Residence	6 🗆 Othe	or (Specify)					
DING PHYS After this death with	B	1 Natural 5 Pen 2 Accident Inve	(Month, Day, FOUND:3-22	28e. DATE OF INJURY FOUND: 3-22-93  28e. PLACE OF INJURY At home, farm, street, factory, office		AK? ES 2 🔯 NO	28d. OESCRIBE HOW INJURY OCCURED  SUBJECT HANGED SELF  28f. LOCATION (Street and Number or Rural Route Number,		Mumbas					
OH ATTENDING DIRECTOR: After hours after death tem 28 is ma	ETED	4 Homicide deta	aid not be armined	building, atc	: (Specify)	OUSE				Silv	or Town, State	19 Brah	ims Ct	•
2 7 E	COMPLET	(Check only one) 2 MEDICAL	EXAMINER: 0	N: To the best of my On the basis of exam									euse(a) an	d manner as stated.
TO The Within 7 IMPORTANT:	TO BE	29b. SIGNATURE AND TITLE OF	0	- Ora	100	>			29c. LICENSE NUI	MBER	6	29d. DATE S	IGNEO (MC	onth, Day, Yoar) 2-93
		30. NAME AND ADDRESS OF PE	HSON WHO C	uber				ISC	ionsin	4	suc	Be	100	s and
-		31. DATE FILED (Month, Day, Year	n	32. REGISTRAR'S					3.2 4	c	-	1	-	



5	MVISION OF VITAL RECORDS, P.O. BOX 68760,	5	5	5	4	١	Š	5	ä	J.	o.	n	×	687	50,		
뜽	UR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours	ING	PHYSIC	AN.	E e	W.	requires	that	the	death	certific	ate	90	excuted	within	54	DOURS
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burial-transit permit Pages 1 2 3 should			
director, page 5 should be detached for use as the		er must be notified at once.	
ding physician and completely filled in by the funeral di	ne prior to burial, cremation, or removal.	her traumatic event, the medical examin	
vis certificate has been signed by the attending	vith the State Dept. of Health and Mental Hygin	ted, or item 23 shows any injury, or other traumatic event, the mi	
THE NUMERAL DIRECTOR: After the	se filed within 72 hours after death with	MPORTANT: If item 28 Is mark	

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH
MONTH
HARCH 3. TIME OF DEATH MARIE ROWLE 0 100 A M 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH
(Month, Day, Year)
MARCH 10, 1904 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign DAYS HOURS IRELAND 1 - M 2 - F 081-32-6311 89 YRS. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH c. COUNTY OF DEATH DIRECTOR WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND MONTGOMERY KENSINGTON 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3000 McCOMAS 20895 AVENUE USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 X Never Merried 2 Married BY 3 Widowed 4 Divorced WWII WHITE COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 4 ARMY OFFICER, Lt. Col. U.S. ARMY NURSE CORP. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) PHILIP ROWLEY BRIDGET BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 BEATRICE **PYATT** HCR Box 211, WEST FULTON, NY 12194-9701 20a. METHOD OF DISPOSITION
1 □ Burial 2 □XCremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - Cify or Town, State DATE METROPOLITAN CREMATORY 4 Donetion 8 Other (Specify) 3/26 ALEXANDRIA, VA 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
FRANCIS J. COLLINS FUNERAL HOME, INC.
500 UNIVERSITY BLVD., W., SIL. SP., MD 2090 23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximete shock, or heart feilure. List only one ceuse on eech line. interval Betwe IMMEDIATE CAUSE (Finel Onset and Death disease or condition nenonia 10 days resulting in death) DUE TO (OR AS A CONSEQUENCE OF) Cardio rusan tory arrest CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24a. WAS AN AUTOPSY ongestine 1 YES 2 NO 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) 1 YES 2 NO OTHER: Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 3.23.93 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Metural 5 Pending 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homicide 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the beats of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER
CORPORATION OF CONTINUES 28d. DATE SIGNED (Month, Day, 160)
3 . 24 · 93 BE 29c. LICENSE NUMBER 2

1299-Lamberton

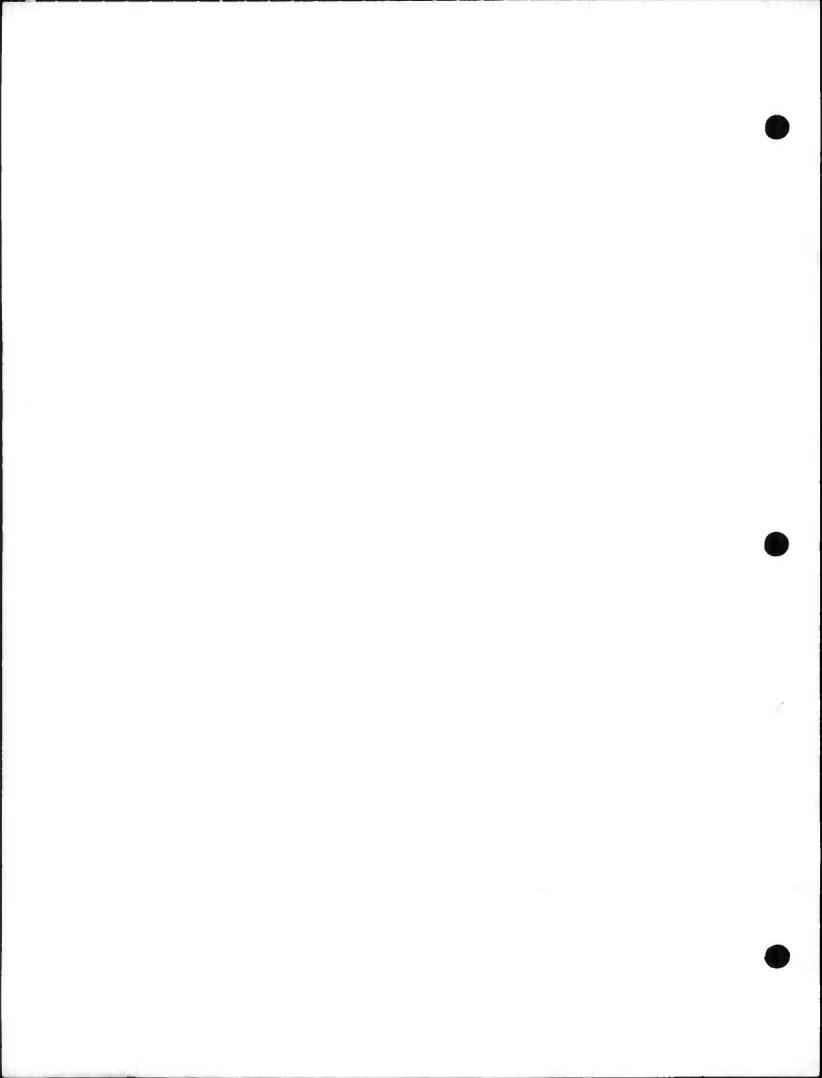
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

KHALLD MD.

32. MEGISTRAB'S SIGNATURE

MOHAMMAD-A.

31. DATE FILED (Month



DIVISION OF VITAL RECORDS, P.O. BOX \$8760.  OR ATTENDING PHYSICIAN: The as been signed by the attending physician.  ORRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should hours after death with the State Dept. of Health and Menial Hyperip prior to burial, cremation, or removal.	them 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
BALT s after death. by the funeral	dical exami
ITAL PECORDS, P.O. BOX 68760, N: The law reporter than the death certificate be becouded within 24 hours after death ficate has been signed by the attending physician and completely filled in by the fune. State Debt. of Health and Menjal Hyperip prior to burial, cremation, or removal.	rvent, the me
OX 687 e be becuted siclan and con	traumatic e
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CORDS gree by the sath and Mer	s and info
ALEREC	MOUS SZ W
OF VIT MYSICIAN: T his certificate with the Stat	IANI: If Item 28 is marked, or ite
DIVISION OF V COPITAL OR ATTENDING PHYSICIAL UNERAL DIRECTOR: After this certif Ithin 72 hours after death with the	E
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	FOR 1 - STATE REGISTRAR	STATE OF MARYL		TMENT OF H		IENTAL HYGIEN		
9000	1. OECEDENT'S NAME (First, Middle, Lest) MATTHEW	MATTHEW Mc	CENEY R RILEY	ILEY		2. DATE OF DEATH MARCH 24,	MY 1993 YEAR	3. TIME OF DEATH 7:35 A
	4. SOCIAL SECURITY NUMBER 213-56-5161	M 2 □ F 3	(In yrs. last birthday) 7 YRS.	IF UNDER 1 YEAR MONTHS DAYS		7. DATE OF BIRTH (Month, Day, Year) APRIL 3,	Coun	HPLACE (State or Foreign try) SHINGTON, DC
TOR	98. FACILITY NAME (If not institution, give THE JOHNS HOPKII RESIDENCE OF DECEDENT				RE CITY	ATH	BALTIMO	
DIRECTOR	10a. STATE 10b. COUNT	Y NTGOMERY		Y, TOWN OR LOCAT				10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	10e. STREET AND NUMBER	PLACE			ZIP CODE	2	10g. CITIZEN OF	WHAT COUNTRY?
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1  YES IF YES, GIVE WAR OR D	2 V NO	If yes, spe		C ORIGIN? (Specify Ye, Puerto Rican, etc.)	s or No- 14, RAC	E American Indian, ck, White, atc.
COMPLETED	15. OECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)			USUAL OCCUPATIO work done during mos se retired.)		16b. KIND OF BU	SINESS/INDUSTRY	WILLE
SOMPL	17. FATHER'S NAME (First, Middle, Last)	1	OWNER/C	PERATOR			AURANT	
	ALFRED B.	RILEY, SR.			ANNE	E (First, Middle, Maiden C •	McCEl	JFV
TO BE	19a, INFORMANT'S NAME (Type/Print)	KIDDI; DK.	19b. MAILING	ADDRESS (Street a		oute Number, City or Tox		(L)
_	ALFRED B. RILEY,					THERSBURG		
	1 KBurlai 2 Cremation 3 Rem	noval from State cen	netery, cremetory or o			1	OCATION — City or T	
	21. SIGNATURE OF FUNERAL SERVICE LI		AIL OF I		D ADDRESS OF FACE			
	Jemothy	4. Cause	el	1500 UN	IVERSITY	LINS FUNE	., SIL. S	INC. SP., MD 20901
		complications that cause List only one cause on e	d the death. Do reach line.	not enter tha mod	de of dying, such	as cardiac or resp	iratory arrest,	Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	Hemor			y 4.040			Onset and Death
z			CONSEQUENCE O					12 hours
ATIO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEDUENCE	P):	nit di	110010		1,,,,,,
FIC	CAUSE (Disease or Injury that Initiated events	C. DUE TO (DR AS /	CONSEQUENCE OF	F):	5071 CC	transp	0 —	IMONGE
CERTIFICATION	resulting in death) LAST	. Alloge	ineic !	sove w	anow	transp	sland	48 days
AL	PART II. Other significant condition	0 1		In the underlying	cause given in P	Part I. 24e. WAS AN	LAÚTOPSY 24	b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO
PHYSICIAN: MEDIC		e. Ketvac Le	ukem	tome 1	melojer	- THES:	2  NO	COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		28. PL	ACE OF DEATH (Chec	ok only one)		
PHYS	1 YES 2 YNO  27. MANNER OF DEATH  1 Natural 5 Pending	1 ☑ inpatient 2 ☐ ER/Outs  28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	4 Nursing Home E OF 28c. INJURY WO	RK?	Other (Specify)  28d. DESCRIBE HOW	INJURY OCCURED	
ED BY	2 Accident Investigation 3 Suicide 6 Coyld not be 4 Homicide defermined	28e. PLACE OF INJURY building, atc. (Spec	— At home, ferm, i		ES 2 NO	261. LOCATION (Street City or Town, State)	and Number or Rural	Route Number,
COMPLET		ICIAN: To the best of my know ER: Dn the basis of examination						s) and menner as stated.
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIE	1 Fellow		cology	29c. LICENSE NUME D 396	BER 79	29d. DATE SIGNED	24 93
	INCUIAL I.	MSDonagh	an.	John	140p1	ins Ouc	cology (	center
	MAR 26 '93	32. REGISTRAR'S SIGN			V		0	

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arter Death	ificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the	noval.	cal exam	
II 24 HOUS AITER DEAD	filled in b	on, or ren	ne medi	
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ratologi	this certi	with the	irked, or	
CADING	OR: After	fter death	8 Is ma	
O THE LINE OF ALLENDING PRINCIPLE	L DIRECT	in 72 hours after death with the State Dept. of Health and Mental Hygiene	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be	
1	FUNER	be med waterin 72 hour	STANT: 1	
	THE FUNE	De Alle	IMPO	

93 09758 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR ERMA K. REINTZEL 03/24/93 8:51 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign 1 M 2 X F MONTHS DAYS 578-16-5763 12/25/911 WASH. DC. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR FORT WASHINGTON MEDICAL CENTER FORT WASHINGTON PRINCE GEORGE'S 10a. STATE 10b. COUNTY 10c. CITY, TOWH OR LOCATION 10d. INSIDE CITY MD PRINCE GEORGE'S 1 XYES 2 NO FORT WASHINGTON FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 2005 BRIER HILL U.S.A. 20744 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY 1 YES 2 NO Specify 3X Widowed 4 Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 RET .- ADMINISTRATOR FED. GOV'T 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Sumame) LAWRENCE RICKER BE VIOLA SNEIDER 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 CHRISTINE FREEZE SAME AS TTEM 20a METHOD OF DISPOSITION
1 Burlet 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE 4 ☐ Donetion 5 ☐ Other (Specify) FT. LINCOLN CEMETERY 3/29/93 BRENTWOOD. MD. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 14 M00091 W. W. CHAMBERS CO., RIVERDALE, MD. 20737 23. PART I. Enter the diseeses, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ehock, or heart fellure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Fine) Onset and Death disease or condition DUE TO (OR AS A CONSEQUENCE OF): resulting in deeth) Chranic Obstructive Pulmanary Disease CERTIFICATION 54m Sequentially list conditions. MEDICAL

If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	OUE TO (OR AS A CONSEQUENCE OF):		
that initieted evente resulting in deeth) LAST	OUE TO (OR AS A CONSEQUENCE OF):		
PART II. Other significent condit	ions contributing to deeth but not resulting in the underlying cause given in Part I.	24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO	24b. WERE AUTOPSY FINDING AWALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
		1	1 TYES 2 T NO

5. WAS CASE REFERRED TO MEDICAL			26. PLACE OF DEATH (C)	neck only one)	_
1 YES 2 NO	HOSPITAL: 1 □ Inpatient 2 □ ER/Outpatient 3	OSPITAL:    Inpatient 2   ER/Outpatient 3   DOA   4   Nursing Home 5   Residence 6   Other (Specify)			
7. MANNER OF DEATH  1 Netural 5 Pending 2 Accident Investigation	26a. OATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	8c. INJURY AT WORK? 1 YES 2 NO	28d. DEŞCRIBE HOW INJURY OCCURED	
3 Suicide 6 Could not b		ome, farm, atreet, fector	y, offica	261. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one)

	, in my opinion, death occured at the time, data and plac	e, and due to the cause(a) end manner ee stated
296. SIGNATURE AND TITLE OF CERTIFIER Holds	29c. LICENSE NUMBER  DO 73 48	29d. DATE SIGNED (Month, Day, Year)  3 - 25 - 93

38. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print

R.M.NEDZ	BRLA, MO. 11761	 Rd FT	WASK. MO	20744
MAR 26 '93	32. REGISTRAR'S SIGNATURE			

FINDINGS

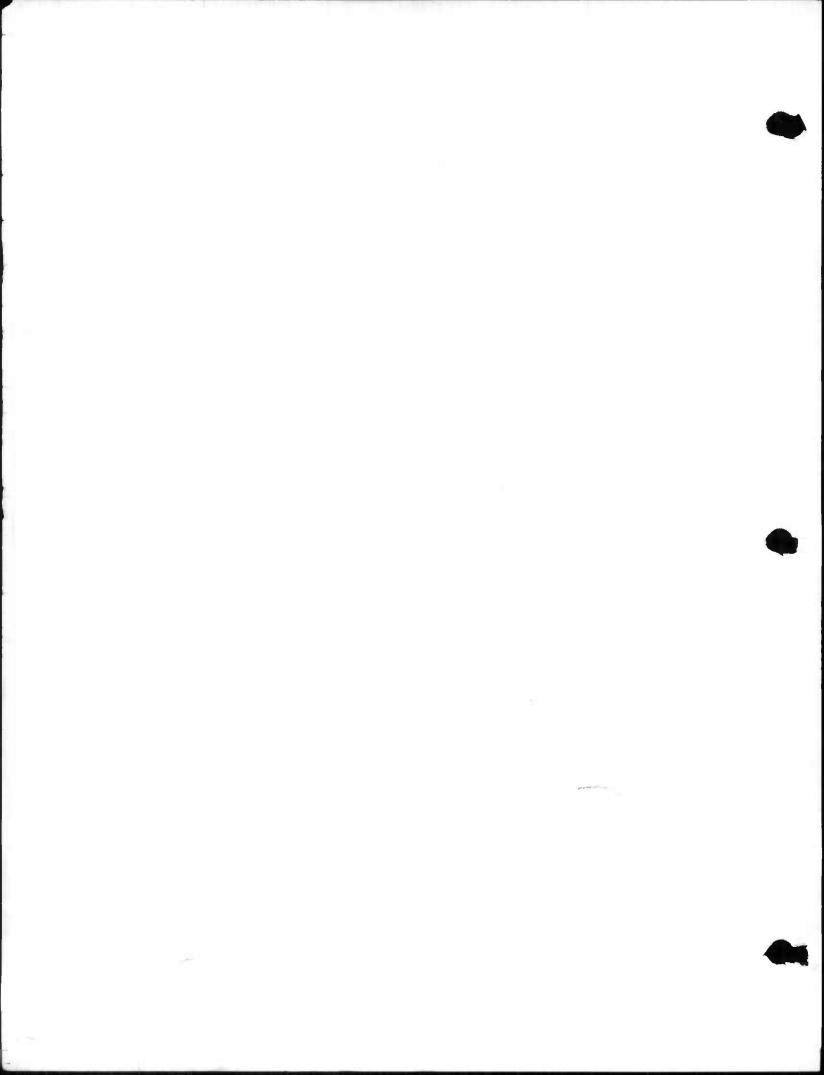
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	LORALIENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be ret	THE FLOW OF ALL ENUMBER PRESENCE OF THE NAME OF THE PROPERTY O	THE TAY IN THE OWNER STATEMENT THE SAY REQUEST HIS DESCRIPTION OF THE OWNER STATEMENT AT FOUR STATEMENT HER DESCRIPTION OF THE OWNER STATEMENT AT ST	THE TAY ALL ENGINE PRINCIPLY IN EAR REQUEST HAT DE GESTI CENTICATE DE OCCUSE WITHIN 24 NOVES AIRE DESTINATION IN THE TAY ALL ENGINE AIRE DESTINATION OF A STANDARD SHAPE AIR DESTINATION OF A STANDARD AIRE DESTINATION OF HEALTH AND MENTAL PHYSICAL OF PRINCIPL AIR DESTINATION OF HEALTH AND MENTAL PHYSICAL OF DUTAL CENTRATION OF REMOVAL.  INFORMANT: If I I I I I I I I I I I I I I I I I I

	1 - FOR STATE REGISTRAR	STATE OF MARYLAN	ND / DEPART	MENT OF H	EALTH AND DEATH	MENTA	AL HYGIEN							
	1. DECEDENT'S NAME (First, Middle, Last)						E OF DEATN			3. TIME OF DEATH				
1 8	Hadassah		Russell			Mar		1993	YEAR	2:05P.M M				
1 8				IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTN th, Day, Year)		8. BIRTH Countr	IPLACE (State or Foreign				
	0.0 00 0000	<sup>1 □ M 2</sup> X F 85	YRS.	IONTHS DAYS	HOURS MIN.	12-	4-190	7		ington, Do				
-	9a. FACILITY NAME (If not institution, give street	et and number)	9	96. CITY, TOWN O	IR LOCATION OF D	EATH			NTY OF D					
2	Memorial Hospita	al at Easton		Eastor	n			Tal	lbot					
DIRECTOR	10e. STATE 10b. COUNTY		10c. CITY,	TOWH OR LOCAT	ION					10d. INSIDE CITY				
	N.H. Gra	afton	Sı	ugar H	ill					LIMITS?				
AL	10s. STREET AND NUMBER			. 101.	ZIP CODE			10g. CITI	ZEN OF Y	VHAT COUNTRY?				
FUNERAL	Pearl Lake Roa				03585	5		US	SA					
E	11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEDENT EVER IN U. FORCES? 1 YES	S. ABMED	13. WAS DECI	ENDENT OF HISPAI	NIC ORIGI	N? (Specify Yes	or No-		- American Indian, k, White, atc.				
BY	3XXVIdowed 4 Divorced	IF YES, GIVE WAR OR DATE			2 NO Specif				Speci					
	15. DECEDENT'S EDUCA	TION 16	Se. DECEDENT'S US	SUAL OCCUPATIO	N .	16	b. KIND OF BUS	INESS/IND	USTRY	WILLCE				
E .	(Specify only highest grade co	College (1-4 or 5+)	(Give kind of wor life, Do NOT use i	rk done during mos retired.)	st of working									
MP I			House	ewife										
TO BE COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA			Surname)						
BE	Johnson Hellen				Mary									
2	19a. INFORMANT'S NAME (Type/Print)				nd Number or Rural									
	Gwynn Leonard 20a. METHOD OF DISPOSITION					tt R	d.,St	. M	icha	aels, MD				
	1 Donetion 5 Other (Specify)	al from State   camete	ACE AND DATE OF	r place!			20c. LO							
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE	lisbury	22. NAME AN	ATORY D ADDRESS OF FA	3-1	6 [Sa1	1sbu	ıry,	MD				
				Newn	am Fune	eral	Home	, P . A	١.					
	23. PART I. Enter tha diseases, or cor	MERCERON	CFS P	200	S. Harı	riso	n St.	, Ea	sto					
	anock, or heart fellure. Lis	st only one ceuse on each	ine.	t anter the mod	re or dying, suc	n ss cer	ulec or respi	retory sm	est,	Approximate Interval Between				
	IMMEDIATE CAUSE (Finel disease or condition	FRACTUR	V= Ric	1+6	24 (7					Onset and Death				
	resulting in desth) s.	DUE TO (OR AS A CO	ONSEQUENCE OF):	~ 16,	riaic	<u>.</u>				6 weeks				
	disease or condition resulting in desth)  Sequentisity list conditions, if any, leading to immediate  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):									6 andes				
Z	Sequentially list conditions,  DUE TO (OR AS A CONSEQUENCE OF):													
VIION		DUE TO (OR AS A CO	ONSEQUENCE OF):	1					csuse. Enter UNDERLYING					
ICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury			V										
TIFICATION	cause. Enter UNDERLYING	DUE TO (OR AS A CO		V										
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CO	ONSEQUENCE OF):											
4	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significent conditions	DUE TO (OR AS A CO	ONSEQUENCE OF):			Part I.	24a, WAS AN		24b.	WERE AUTOPSY FINDINGS				
4	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significent conditions	DUE TO (OR AS A CO	ONSEQUENCE OF):			Part I.	24a, WAS AN PERFOR	MED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
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4	cause. Enter UNDERLYING CAUSE (Dissess or injury that initiated events resulting in death) LAST  PART II. Other significent conditions  Alguera	DUE TO (OR AS A CO	not resulting in	26. PLJ	ACE OF DEATN (Ch	eck only o	PERFOR  1  YES 2 / ne)	MED?		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
PHYSICIAN: MEDICAL	cause. Enter UNDERLYING CAUSE (Dissess or injury that initiated events resulting in death) LAST  PART II. Other significent conditions  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 © YES 2 □ NO  1. Netural 5 □ Pending	DUE TO (OR AS A CO	not resulting in	26. PLIDTHER: Nursing Home of the Woof Wood	ACE OF DEATH (Ch	eck only o	PERFOR  1 YES 2  /  ne)  PEr (Specify)  SCRIBE NOW IN	MED?		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
BY PHYSICIAN: MEDICAL	Cause. Enter UNDERLYING CAUSE (Dissess or injury that initieted events resulting in death) LAST  PART II. Other significent conditions  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 NO  1.  NAMINER OF DEATN	DUE TO (OR AS A CO	not resulting in	26. PLJ DTHER: Nursing Home THER: WOF 1 1 1	ACE OF DEATN (Ch.  1 S	s Other	PERFOR  1 YES 2  //  PERFORM  1 (Specify)  SCRIBE NOW IN  UBJECT F	JURY OCC	CURED or Rural R	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO				
BY PHYSICIAN: MEDICAL	Cause. Enter UNDERLYING CAUSE (Dissess or injury that initieted events resulting in death) LAST  DART II. Other significent conditions of  EXAMINER?  YES 2 NO  1  Netural 5 Pending Investigation	Contributing to death but    Contributing to death but	not resulting in	26. PLJ DTHER: Nursing Home THER: WOF 1 1 1	ACE OF DEATN (Ch.  1 S	s Other	PERFOR  1 YES 2  //  PERFORM  1 YES 2  //  PERFORM  PERFO	JURY OCC	CURED or Rural R	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO				
BY PHYSICIAN: MEDICAL	Cause. Enter UNDERLYING CAUSE (Dissess or injury that initieted events resulting in death) LAST  DART II. Other significent conditions of the conditions of	Contributing to death but  ( > Perse  ( SPITAL: ) ( Properties 2   ER/Outpaties  ( Month, Day, Year) 2-3-93  28a. PLACE OF INJURY — building, etc. (Specify)  NURSI	not resulting in  ont 3 DOA 4  29b. Timec 5  NJUR 9:30 P  At home, farm, stre	26. PLJ  THER: Nursing Home OF 26c. INJU WOF 1 Y WOF 1	ACE OF DEATN (Ch.  5 G Rasidence  RY AT  RS 2 XX NO	s Otth 26d. DE S 28f. LOO Chy	PERFOR  1 YES 2  //  Per (Specify)  SCRIBE NOW IN  UBJECT F  CATION (Street a or Yown, State)  On, Md.	JURY OCC	or Rural R	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO				
BY PHYSICIAN: MEDICAL	Cause. Enter UNDERLYING CAUSE (Dissess or injury that initieted events resulting in death) LAST  PART II. Other significent conditions of the conditions of	Contributing to death but    Contributing to death but	not reculting in  ont 3 00A C 29b. Time c 18 JUN 9:30 P At home, farm, stre	26. PLJ OTHER: Nursing Home OF WOF 1 Y Net, factory, office	ACE OF DEATN (Ch	s Other	PERFOR  1 YES 2  PER (Specify)  SCRIBE NOW IN  UBJECT F  ATION (Street a or Town, State)  On, Md.  use(s) end man	MED?  AJURY OCC  ELL  AND Number  WM .	or Rural R	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO				
E COMPLETED BY PHYSICIAN: MEDICAL	Cause. Enter UNDERLYING CAUSE (Dissess or injury that initieted events resulting in death) LAST  PART II. Other significent conditions of the conditions of	OSPITAL:  Contributing to death but  Contributin	not reculting in  ont 3 00A C 29b. Time c 18 JUN 9:30 P At home, farm, stre	26. PLJ OTHER: Nursing Home OF WOF 1 Y Net, factory, office	ACE OF DEATN (Ch	s Other 26d. DE S 28f. LOO City East Io the ce time, data	PERFOR  1 YES 2  PER (Specify)  SCRIBE NOW IN  UBJECT F  ATION (Street a or Town, State)  On, Md.  use(s) end man	MED?  NO NO  NJURY OCC  FELL  Ind Number  WM	or Rural R	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO				
BE COMPLETED BY PHYSICIAN: MEDICAL	Cause. Enter UNDERLYING CAUSE (Dissess or injury that initieted events resulting in death) LAST  PART II. Other significent conditions of the conditions of	Contributing to death but  ( > Perse  ( SPITAL: The patient 2 Contribution of the best of my knowledge on the basis of examination and specific contribution of the basis of examination and specific contribution of the basis of examination and specific contribution of the basis of examination and specific contribution of the basis of examination and specific contribution of the basis of examination and specific contributions.	not resulting in  ont 3 000 4  29b. TilMec 9:30 P  At home, farm, stre NG HOME pe, death occurred addor investigation,	26. PLJ THER: Nursing Home OF 26c. INJU WOF 1	ACE OF DEATN (Ch.  To S	eck only o  S Other  26d. DE  S  28f. LOC  City  East  to the ce  time, data	PERFOR  1 YES 2  PER (Specify)  SCRIBE NOW IN  UBJECT F  ATION (Street a or Town, State)  On, Md.  use(s) end man	MED?  NO NO  NJURY OCC  FELL  Ind Number  WM	or Rural R	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  Noute Number, Manor N.H,				
E COMPLETED BY PHYSICIAN: MEDICAL	Cause. Enter UNDERLYING CAUSE (Dissess or injury that initiated events resulting in death) LAST  PART II. Other significent conditions  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  Yes 2	DUE TO (OR AS A CO	not resulting in  ont 3 DOA CONTROL STATE OF STA	26. PLJ DTHER: Nursing Home Nur	ACE OF DEATN (Ch  5 Rasidence RY AT RES 2 XX NO  and placa, and due eath occured at the  29c. LICENSE NUR	eck only o  S Other  26d. DE  S  28f. LOC  Chy  East  to the ce  time, data	PERFOR  1 YES 2  PER (Specify)  SCRIBE NOW IN  UBJECT F  ATION (Street a or Town, State)  On, Md.  use(s) end man	MED?  NO NO  NJURY OCC  FELL  Ind Number  WM	or Rural R	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  Noute Number, Manor N.H,				
BE COMPLETED BY PHYSICIAN: MEDICAL	Cause. Enter UNDERLYING CAUSE (Dissess or injury that initieted events resulting in death) LAST  PART II. Other significent conditions of the conditions of	DUE TO (OR AS A CO	not resulting in  ont 3 DOA Control 3 DOA Control 3 DOA Control 3 DOA Control 3 DOA Control 3 DOA Control 3 DOA Control 3 DOA Control 3 DOA Control 3 DOA Control 3 DOA CONTROL 3 DOA CO	26. PLJ DTHER: Nursing Home Nur	ACE OF DEATN (Ch  5 Rasidence RY AT RS? ES 2 XX NO  and placa, and due enth occured at the  29c. LICENSE NUR	s Other 28d. DE 28f. Loc City East time, data	PERFOR  1 YES 2  PER (Specify)  SCRIBE NOW IN  UBJECT F  AATION (Street a or Youn, State)  On , Md  use(s) end man a and placa, and	MED?  NO NO  NJURY OCC  FELL  Ind Number  WM	or Rural R	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  Noute Number, Manor N.H,				

TOTHE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a Jura after death. Page 6 may be retained by the hos	FUNERAL DIRECTOR: /	within 72 hours after c	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
JING PHYSICIAL	After this certif	death with the	marked, or
V: The law re	icate has bee	State Dept. o	item 23 sh
quires that th	n signed by 1	f Health and	lows any ir
e death ce	the attendir	Mental Hyg	njury, or o
rtificate be	ng physician	tiene prior t	other traus
executed wi	and compl	to burial, cri	matic ever
ithin 2 Su	etely filled in	emation, or	nt, the me
rs after deatl	n by the fun	removal.	edical exar
1. Page 6 m	eral director.		niner must
ay be reta	page 5 st		be not
ined by th	ould be d		fled at o
e ho	letach		nce

	FOR STATE REGISTRAR	STATE OF MARYLA		ENT OF HEALTH ANI	D MENTAL	REG. NO.		3 03/00
	1. DECEDENT'S NAME (First, Middle, Last) Ralph	S. Sauno	ders		2. DATE O MONTH		/21/9 <u>3</u>	3. TIME OF DEATH AM 2.30 AM M
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (1	n yrs. last birthday) IF U	NDER 1 YEAR JF UNDER 24 HR	s. 7. DATE O	F BIRTH Day, Year)	8. E	HATHPLACE (State or Foreign Country)
OR	9s. FACILITY NAME (If not institution, give street acres Laurel 1			CITY, TOWN OR LOCATION OF Laurel		6,9	9c. COUNTY	
DIRECTOR	10e. STATE 10b. COUNTY  MD Prince	Georges	10c. CITY, TO	WN OR LOCATION	namiga			10d. INSIDE CITY LIMITS?  1 7 YES 2 NO
FUNERAL D	100. STREET AND NUMBER 14200 Laurel Par		Lau	10f. ZIP CODE 20707				of WHAT COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	13. WAS DECENDENT OF HIS If yea, specify Cuben, Ma: 1 YES 2 NO Sp	xicen, Puerto R		or No- 14.	Black, White, stc.  Specify:  White
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade or Elementary/Secondary (0-12) 1 2	College (1-4 or 5+)	16e. DECEDENT'S USUA (Give kind of work of life. Do NOT use red)	lone during most of working red.)		KIND OF BUS	eering	RY
E COM	17. FATHER'S NAME (First, Middle, Last) Sidney Saunders		***************************************	To their b	NAME (First, M	liddle, Malden S		
TO BE	190. INFORMANT'S NAME (Type/Print) David Saunders			RESS (Street end Number or Ru				
	20e. METHOD OF DISPOSITION 1	ral from State	. PLACE OF DISPOSITIO other place)	N (Name of cometery, cromatory  CTCTV  22. NAME AND ADDRESS OF	or	20c. LOC	dham,	or Town, State
	21. SIGNATURE OF FUHERAL SERVICE LICE	4	1	Hines-Rinald	di Fune	eral He		r Spring, MD
	23. PART I. Enter the diseases, or co shock, or heart fellure. Li			nter the mode of dying,	auch ee card	lec or reepli	ratory erreat,	Approximate interval Between Onset end Death
	IMMEDIATE CAUSE (Final disease or condition resulting in deeth)	DUE TO (OR AS A	odde~	death				secondi
TION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):	M.El				days
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):					
A	PART II, Other aignificent conditione	contributing to death b			in Part I.	24s. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDIC			*	-				1 TES 2 NO
SICIA		HOSPITAL:		28. PLACE OF OEATH HER: Nursing Home 6 - Resider				
	27. MANNER OF OEATH  1 Natural 6 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJURY AT WORK?  M 1 YES 2 NO	28d. OES		NJURY OCCUR	EO
TED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	26s. PLACE OF INJURY building, atc. (Spec	/ — At home, term, stres	t, fectory, office		ATION (Street a or Town, State)	and Number or F	Rural Route Number,
COMPLETED	enel			the time, data and place, and my opinion, death occured at				suse(s) and manner as stated.
BE	250. SIGNATURE AND THICK OF CERTIFIER	M	14.0	29c LICENSE Dit 27	NUMBER		29d. DATE SI ▶ 3	GNEO (Mdrith, Day, Your)
10	30. NAME AND AUTORESS OF PERSON WHO			) Lone,	Laure	١, ١	MO	20707
	31. DATE FILED (Manth, Day, Your)	32. REDISTRAR'S SIGN	NATURE COMPANDED			-		



r attending physician. use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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THE INSPINE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or	In the American DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for	Market within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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#	1	5 pg	DATE
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Donald

31. DATE FILED Month, Day 1647

G.

Wright,

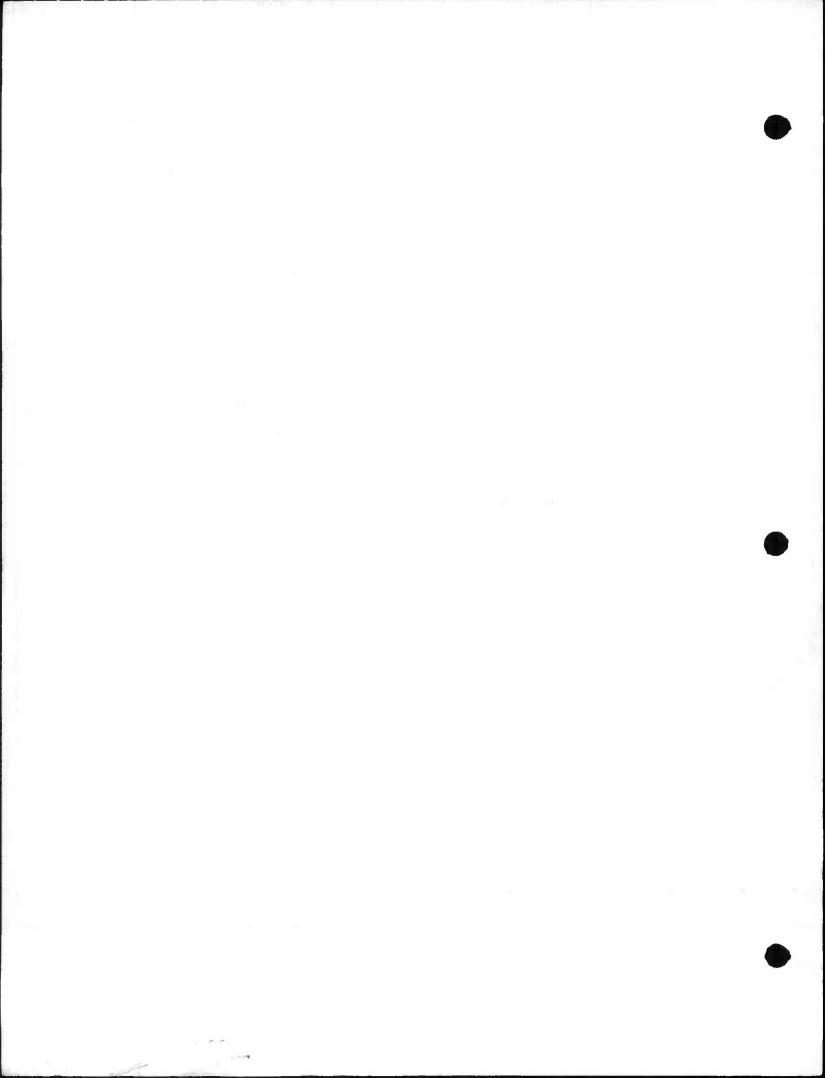
M.D.

32. REGISTRAR'S SIGNATURE
Julia Davidson Randell

												9	3	0976	
	1 - FOR STATE REGISTRAR		STATE OF N	IARYLAND	/ DEPAR	RTMEN	T OF H	DEAT	AND	MENTA	L HYGIEN				
	1. DECEDENT'S NAME (First, Mi	iddle, Last)								2. DATE	OF DEATH			3. TIME OF DEA	ATH.
il	Christop	her	J.O	seph		Sr	ahr			0 3			YEAR		
	4. SOCIAL SECURITY NUMBER		5. SEX	8. AGE (In yrs.	last hirthday)	IF UNDE		IF UNDER	A4 1890		OF BIRTH	/ 1:	993	2:30	PM
	212-68-3747		11√2 M 2 □ F	36	YRS.	MONTHS	DAYB	HOURS	MIN.	(Monti	h, Day, Year)		Countr		
	9a. FACILITY NAME (If not institu			30		9h CITY	TOWN C	R LOCATIO	ON OF DE		18,19		WASH	INGTON,	D.C.
DIRECTOR	15498 Old	Coli	umbia P	ike				nsvi				100		gomery	,
<u>입</u>		DENT 0b. COUNTY			10c CIT	V TOWN	DR LOCAT	ION	_						
E I	MARYLAND MONTGOMERY BURTONSVILLE							10d. INSIDE CIT LIMITS? 1 YES 2							
	10e. STREET AND NUMBER	110111	опын			DOKI		ZIP CODE				10a CIT	17EN OF V	WHAT COUNTRY?	NO
FUNERAL	14907 ATHEY 1	ROAD						208	66			10 81 011			
3	11. MARITAL STATUS		12. WAS DECEOEN	EVER IN U.S.	ARMED	13.	WAS DEC			VIC ORIGIN	f7 (Specify Yes	or No.	US		la a
7	1 Never Merried 2 X Me		FORCES? 1 IF YES, GIVE W	YES 2 F	Мо	- 1	If yes, spe	cify Cuba	n, Mexica	n, Puerto I	Rican, etc.)	0, 110	Black	E — Americen Ind k, White, etc.	twir <sub>t</sub>
Э ВУ	3 Widowed 4 Divorce			19130				91					, appear	WHITE	
ΞI	15. DECEDI (Specify only hi	ENT'S EDUCA		16a.	DECEDENT'S	USUAL O	CCUPATIO	N st of workin	7	16b	KIND OF BUS	INESS/INI	DUSTRY	11-12-20-20-20-20-20-20-20-20-20-20-20-20-20	
4	Elementary/Secondary (0-12)	)	College (1-4 or 5+		life. Do NOT us	se retired.)									
COMPLETED			2	DO	OG GRO	OMER					ET GRO		G SH	IOP	
	17. FATHER'S NAME (First, Middl										Middle, Malden				
BE	C. EDWIN SPA				un constant						CELLA				
2	VICKI L. SPAH		(1111	212)							ber, City or Town				
1	204, METHOD OF DISPOSITION	1	(WII		E AND DATE		-		BUKI	ONSV	ILLE, M	-			
	1 XBuriel 2 Cremation 4 Donation 5 Other (Sp	3 🗆 Remov	rel from State	cemetery.	Crematory or o	ther place)	TINITO	TAT		1			City or To	11500	
	21. SIGNATURE OF FUNERAL S		yate //	I BUK.	LONSVI			D ADDRES	S OF FA	CILITY	3 IROKI	ONSV	TLLE	,MARYLA	ND
	Mark	1	11.1	6//		FR	ANCI	S J.	COL	LINS	FUNER				
-	or carrie	271	Va	un		50	0 UN	IVER	SITY	BLV	D.,W.	SIL.	SPR.	,MD.209	01
	23. PART I. Enter the disecanock, or hear	esea, or co t fellure. Li	mplications that at only one ceu:	ceused the se on each li	deeth. Do i	not anter	the mo	de of dyl	ng, auc	h aa card	flec or reaple	retory an	reat,	Approxin	
	iMMEDIATE CAUSE (Final disease or condition													Onset an	
H	resulting in death)	a.	Han												
			DUE TO	DR AS A CON	SEDUENCE O	F):									
CERTIFICATION	Sequentially list condition		OUE TO (	OR AS A CONS	SEDUENCE O	Pi-								_	
¥	If any, leading to immediate cause. Enter UNDERLYING				JED JE110E 01	,,									
Ĕ	CAUSE (Disease or Injury that Initiated events	C.	OUE TO	DR AS A CONS	SEDUENCE O	F):								-	- 3
E	resulting in death) LAST														J
_	PART ii Other elapiticent	and distance		4											
PHYSICIAN: MEDICAL	PART II. Other algolificant	CONGINIONA	contributing to	weath but no	t reauting	in the un	deriying	ceuae g	iven in	Part I.	24s. WAS AN A		24b.	WERE AUTOPSY I	TO
Ö										-	1 XYES 2	□ NO		COMPLETION OF DF DEATH?	CAUSE
Σ														1 X YES 2 [	ND
AN	25. WAS CASE REFERRED TO M	EOICAL													
<sup>-</sup>	EXAMINER?		HOSPITAL:	92 CA		OTHER		ACE DF DE	EATH (Ch	eck only on	0)				
₹ ¥	1 VES 2 ND 27. MANNER OF DEATH	1	Inpatient 2		_	4 🗆 Nun	sing Home	5 🗆 Re	sidence	8 TOther		Plac	e of	f Busi	ness
	1 Netural 5 Pen	iding	26e. DATE OF (Month, Da		28b. TIM INJ	URY	26c. INJU	RK2			CRIBE HOW IN			TT 1	
B	2 Accident	etigation		1993		2 P	1 💢 Y	ES 2	ND					Himse	TI
8	3 Suicide 6 Cou	ald not be ermined	28e. PLACE DF building, o	itc. (Specify)	Pet					261, LOCA	ATION (Street a or Town, State) 98 O.				
<u> </u>	29e. CERTIFIER													mbia P	ıke
d N	(Check only		AN: To the best of a												
COMPLETED	2 XMEDICAL		On the basis of ax	mination and/	or investigatio	n, in my o	pinion, de	eth occur	ed at the	time, data	and place, end	due to th	e ceuse(a)	) and menner as :	stated.
BE	296. SIGNATURE AND TITLE OF		~//					29c. LICE				29d. DAT	E SIGNED	(Month, Day, Year)	
2	would !		ight M					0.0	C.M	.E.		<b>&gt;</b>	03/1	18/199	3
-	30. NAME AND ADDRESS DF PE	RSDN WHO	COMPLETEO CAUS	E OF DEATH (I'	TEM 27) (Туре,	Print)									

111 Penn Street, Baltimore, Maryland

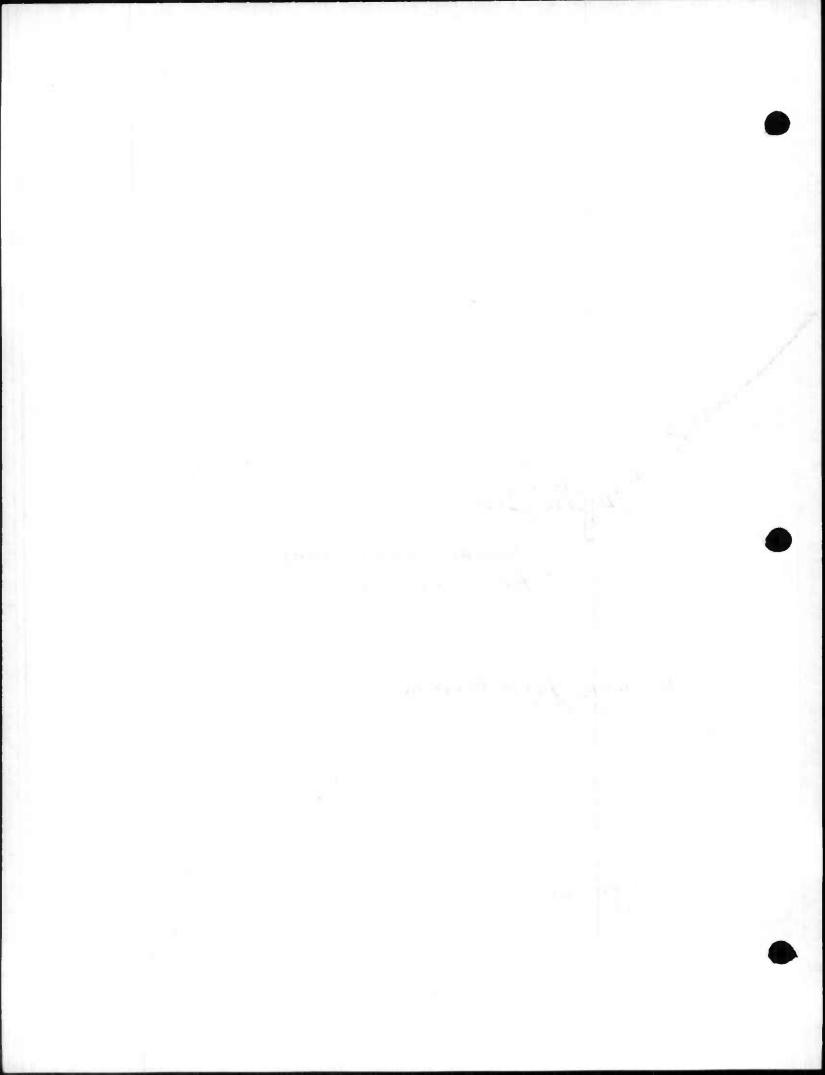
21201



FOR STATE

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CE	RTIF	CATE (	F DEATH		REG. NO.				
	1. OECEDENT'S NAME (First, Middle, Last)						2. DATE OF	DA	v	WEAR	3. TIME OF OE	ATH
		HACHAT					MARCH	18,	1993	3 1220	8:25	P. M
	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. last		MONTHS DA		7. DATE OF (Month, D	wy. Year)		8. BIRTNP Country	LACE (State or	Foreign
	158–10–8776  9e. FACILITY NAME (If not institution, give s	1 M 2 X F	79	YRS,		200	MAY 1	7, 19	13	NEW J	JERSEY	
Œ						VN OR LOCATION OF D	EATH		9c. COU	NTY OF DE	ATH	
HEBREW HOME OF GREATER WASHINGTON ROCKVILLE						VILLE			MON	TGOME	ERY	
DIRECTOR					, TOWN OR LO	CATION					10d. INSIDE CIT	γ
5	MARYLAND MONTGOMERY				LVER S	PRTNG					LIMITS?	NO.
FUNERAL	10e, STREET AND NUMBER					101. ZIP CODE			10g. CIT		AT COUNTRY?	
E	812 HYDE COURT					20902			UNT	TED S	TATES	
5	11. MARITAL STATUS	12. WAS OECEDENT	EVER IN U.S. ARM	MED	13. WAS	DECENDENT OF HISPA	NIC ORIGIN? (S	Specify Yes		14. RACE -	- American Inc	llen,
ВУ	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WA		•		yes 2 NO Specific		in, inc.j		Specify		
	15. DECEDENT'S EDU	CATION	16a DE/	EDENT:0	USUAL OCCUP	171011	The same and				ITE	
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Gh	w kind of w Do NOT use	ork done during	most of working	16b. KI	NO OF BUS	INESS/INI	DUSTRY		
립	12	college (I-4 di 5+)		OOKKI	EEPER		CM/	ATT R	HCTN	ESSES		
COMPLETED	17. FATNER'S NAME (First, Middle, Last)					18. MOTNER'S NA				POOPO		
BE	HARRY FEDOL					FANNY		SI	KIRL	LOFF		
2	19a. INFORMANT'S NAME (Type/Print)		19b.	MAILING	ADORESS (Str	et and Number or Rural	Route Number,	City or Town	, State, Zir	Code)		
-	FRAN HAKIM (DAU	GHTER)	8.	12 HY	DE CO	URT, SILVE	R SPR	ING.	MD 2	0902		
	20s. METNOD OF DISPOSITION  1 X Buriel 2 Cremation 3 X Rame	oval from State	20b. PLACE A	ND DATE O	FDISPOSITION		OATE			City or Town	n, Stata	
-	□ Donation S □ Other (Specify)     21. SIGNATURE OF FUNERAL BETWEE LIC		ROYAL	PALM	S CEME		3/21	W. P	ALM	BEACH	I, FLOR	RIDA
- 1	II. SIGNAT ONE OF THE CO.	L .			DANZ.	ANSKY—GOLD	RERC N	(FMOD	TAT	СПУБЕ	TC TM	C
	Jacy M	This	0		1170	ROCKVILLE	PIKE.	ROCI	KVTT.	T.F M		
	23. PART I, Enter the discusses, or of shock, or hear failure.	ongoications that	causad the dea	th. Do no	ot anter tha	mode of dying, auc	h as cardlad	or respir	atory an	rest,	Approxim	nata
ı i	IMMEDIATE CAUSE (FIn	Cost Only One Causi		^							Onset an	
	disease or condition resulting in death)	CARDI	AC	HK	RYTH	IMIAS						
ľ		OUE TO (C	OR AS A CONSEQU	JENCE OF	):							
S I	Sequantially list conditions,	b. PENA	OR AS A CONSECU	1/1/	CRE							
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	302 10 (0	AS A CONSECU	JENCE OF	1.							
ピⅡ	CAUSE (Disease or injury that initiated events	DUE TO (C	OR AS A CONSECU	JENCE OF	):						-	
토	resulting in daeth) LAST										1	
5	DADT II. Other electrons are that	4.74										
3	ABDONINAL A	A			tha undari	ing cause given in	Part I. 24	PERFORM			VERE AUTOPSY F	
	THORASIC A	MATI	May 85	140			1	YES 2	NO.		DMPLETION OF F DEATH?	CAUSE
Ξ	THURMSIC MI	THE P	INEUN	YYN						1	☐ YES 2 ☐	NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL					L						
SIC	EXAMINER? 1 YES 2 X NO	HOSPITAL:	ER/Outpetlant 2 [		OTHER:	PLACE OF DEATH (Ch						
Ë	27. MANNER OF OEATN	28a, DATE OF IN	JURY	28b. TIME	OF 28c.	INJURY AT	6 ☐ Other (Sc 28d. DESCRI		IURY OCC	CUREO		
2 8	1 Netural 5 Pending	(Month, Day,	( Year)	INJU	RY	WORK? NO				JOHLO		
- 46	3 Suicide 6 Could not be	26s. PLACE OF I	INJURY At hom	e, farm, st	rsat, factory, c	ffica	28f, LOCATIO	N (Street an	nd Number	or Rural Rou	ite Number,	
<u>"</u>	4 Nomicide determined	bollong, at	c. (Specify)				City or 16	wn, State)				
COMPLETED	29a. CERTIFIER (Check only 1 X CERTIFYING PHYSIC	CIAN: To the beat of m	y knowledge, daat	h occurred	f at the time, o	ata and place, and due	to the causels	) and mann	or an etat	ari .		
S	one) 2 MEDICAL EXAMINER										end manner as a	stated,
	296. SIGNATURE AND TITLE OF CERTIFIER					29c. LICENSE NUM				E SIGNED (A		
2 2	Malyn 16	mun	mis	PH	MSILI	AN DZ-	5791			3/19	1/50	
2	Ja. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF OEATN (ITEM	27) (Type, I	Print)		/ //		,		115	
	MERLYN K. VEMURY,	M.D., 103	01 GEOR	GIA	AVENUE	, #305 SI	LVER S	PRTNO	. MT	200	902	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR	S SIGNATURE			, . JUJ DI.	TANK D	T WING	, FIL	, 20	702	
	MAR 22 '93	Juna D	avidson R	indelle								



attendi	ID * THENTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as to		
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THE THE THE THE THE PRINCIPLY THE DAM LEGATIVE THE DESCRIPTION WITHIN 24 HOURS SITE DESCRIPTIONS OF THE DESCRIPTION OF THE DESC	fune		MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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93 09763 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Judith Sims YEAR Mar. 1 1993 PM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. lest birthday) 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 X F 70 394-12-1963 YRS May 3,1922 Wisconsin 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Montgomery General Hospital Olney Montgomery RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Silver Spring 1 X YES 2 NO FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 3330 N. Leisure World Blvd. #722 20906 U.S.A. 11. MARITAL STATUS 12, WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE - American Indian, Black, White, etc. FORCES? 1 YES 2 NO 1 Never Married 2 Married Spec#y: white 1 TES 2 NO Specify: BY 3 Widowed 4 X Divorced COMPLETED 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5 +) deputy ambassador United Nations 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Charles Fisher Anna 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Charles E. Bullock 5118 Dalecarlia Dr., Bethesda, Md. 20816 20a. METHOD OF DISPOSITION

1 Substitution 2 Cremation 3 Res
4 Donation 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, Stata Gate of Heaven Cem., March 20,93 Silver Spring, Md. 22. NAME AND ADDRESS OF FACILITY
DeVol Funeral Home 21. SIGNATURE OF FUNERAL SERVICE LICE 2222 Wisconsin Ave., N.W., Wash., DC 20007 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart sallure. List only one cause on each line. Approximate interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) 2410 DUE TO (DR AS A CONSEQUENCE OF): DS PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, Replined, v &1. Besed Wwar if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMED? Deknoso hypositis 1 | YES 2 | NO OF DEATH? unfulation-1 | YES 2 | NO Ventilador 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO me 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28a. DATE DF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO ВҮ 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Laurless his 7 25410 13/18 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

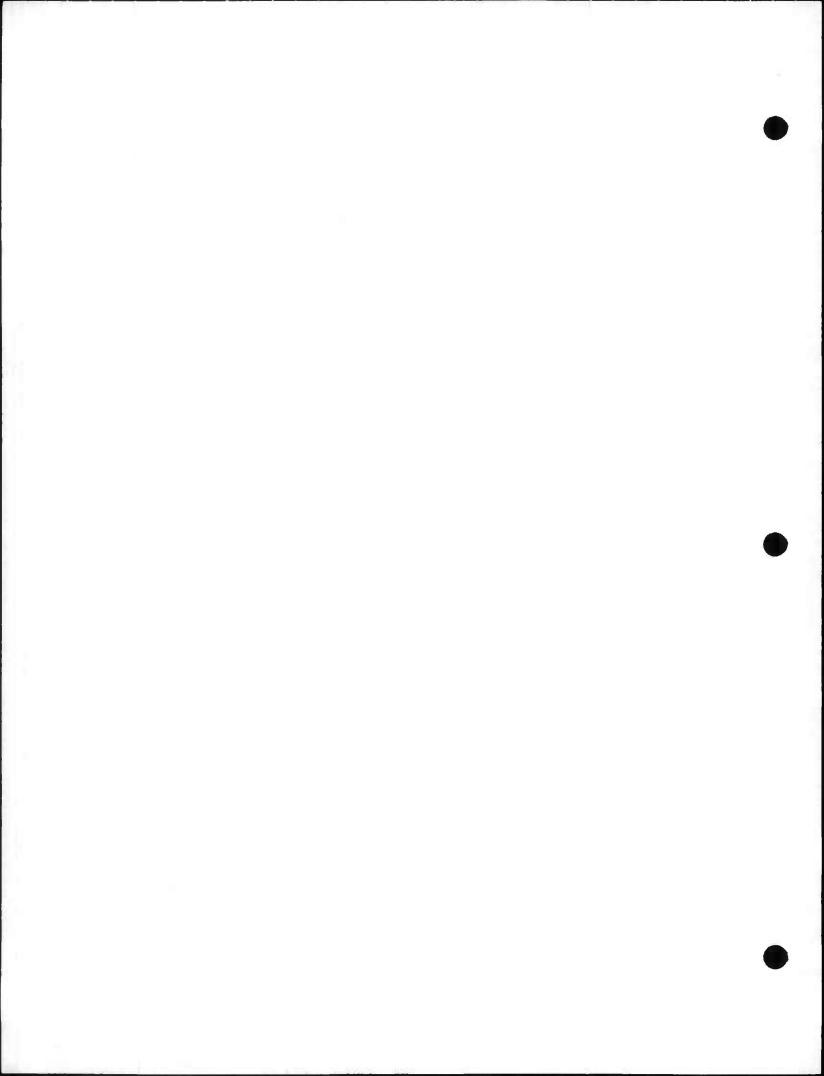
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32. REGISTRAR'S SIGNATURE

wie Davidson Randall

31. DATE FILED (Month, Day, Year) MAR

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THE RECORDS, T.O. BOX 60180,	A AVENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after	INCLURE After this certificate has been signed by the attending physician and completely filled in by the after the with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remo
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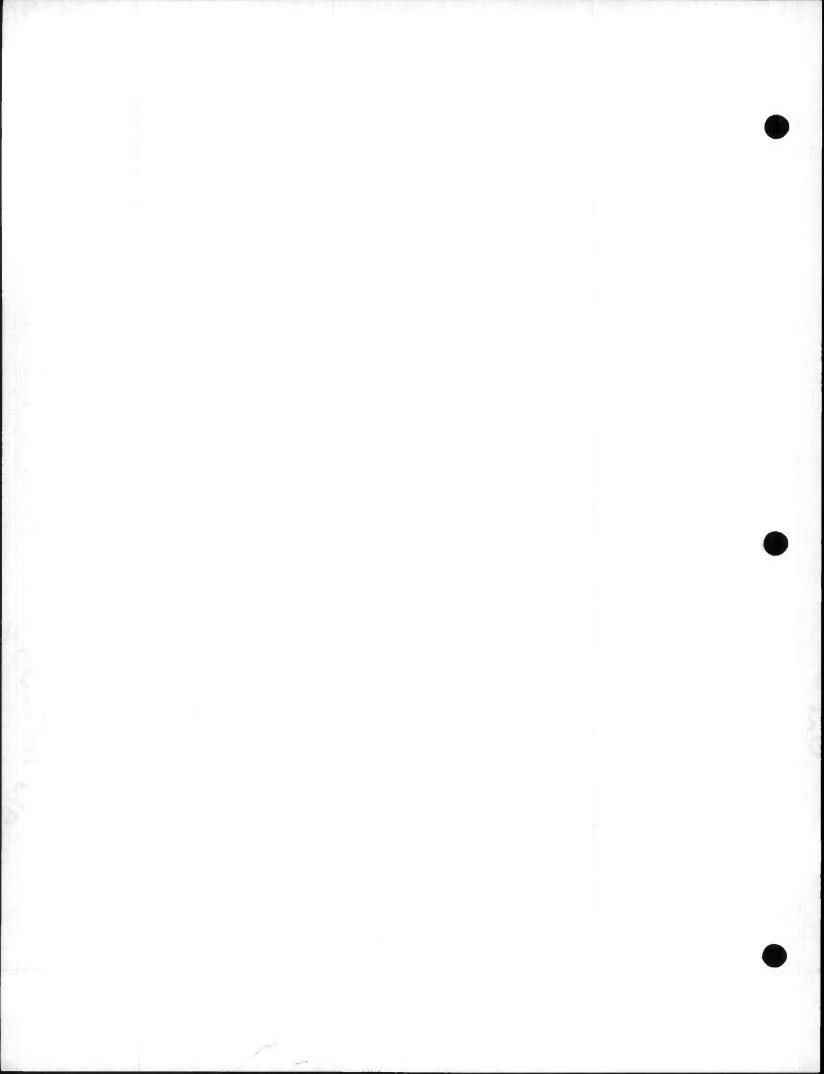
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle Last) 3. TIME OF DEATH YEAR 10:10 A M LILLIAN ADELL SCHUMANN 1993 MAR 21 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 🗌 M 2 🗐 F 077-01-2839 NOV 12 1908 NEW YORK 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYI.AND MONTGOMERY 1X YES 2 NO CHEVY CHASE FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 10f. ZIP CODE 4707 TRENT COURT 20815 UNITED STATES 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 2 XNO 1 Never Married 2 Married 1 TYES 2 NO 8 Specify Specify: 3 Widowed 4 Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp (Give kind of work done Ms. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home HOMEMAKER 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) FRANCIS J. FRANTZ BE ADELL MOSHER 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 2 WATSON 4707 TRENT COURT. CHEVY CHASE MD 20815 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Stata n 3 🗆 Re Arlington, VA "AfTington" National Cem. 3/26 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, DC 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fellure. List only one ceuse on each line. interval Betw **IMMEDIATE CAUSE (Final Onset and Death** disease or condition BOWEL INFARCTION resulting in death) DUE TO (OR AS A CONSEQUENCE OF) STATUS POST RIGHT HEMICOLECTOMY FOR BOWEL INFARCTION CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO OF DEATH? 1 TES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
| Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 TES 2X NO 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural
2 Accident
3 Suicide 5 Pending Investigation 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide

296. SIGNATURE AND THE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) ► 63/23/93 1 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NATIONAL NAVAL MEDICAL CENTER DUNNE. LT. MC USNR BETHESDA MD 20889-5600 31. DATE FILED (Month, Day, Year) Julia Savidson .03 Mandell

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occursed at the time, data and place, and due to the cause(s) and menner as stated.

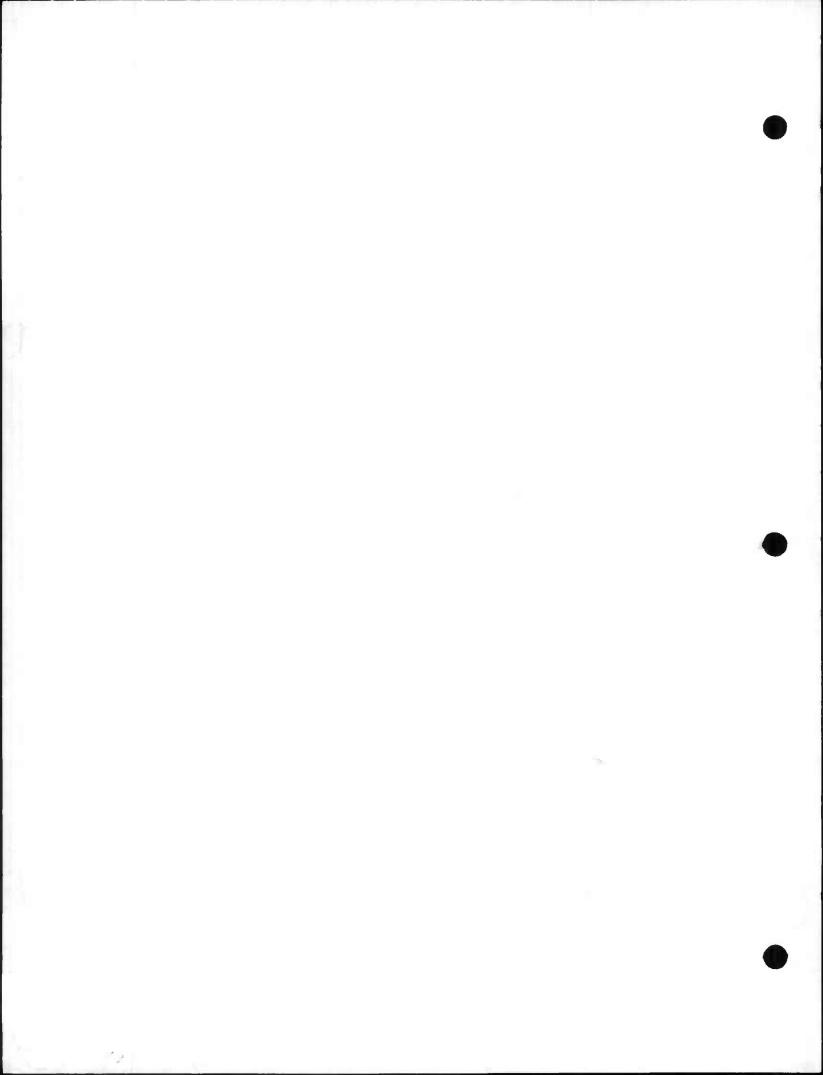
29a. CERTIFIER

//Chack nniv 1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.



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1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.											
	1. DECEDENT'S NAME (First, Middle, Last	0	2. DATE OF DEATH	-	3. TIME OF DEATH						
		Ann S. Sl	nea			March 19,	1993 YE	1:10 P M			
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8.1	BIRTHPLACE (State or Foreign Country)			
	578-24-1797		70 YRS.			Aug. 8, 1	922 Wa	ashington, DC			
· c	9e. FACILITY NAME (If not institution, give				R LOCATION OF DE	ATH	9c. COUNTY	OF DEATH			
DIRECTOR	206 New Mark Esp	olanade	ckville		Мс	ontgomery					
E E	10a. STATE 10b. COUN	ITY	ON			10d. INSIDE CITY					
	Maryland	Montgomery		Ro	ckville		LIMITS? 1 🖺 YES 2 □ NO				
FUNERAL	A CONTRACTOR OF THE PROPERTY.	10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF									
N.	206 New Mark Est	12. WAS DECEDENT EVER I			20850			States			
	1 Never Married 2 Married	FORCES? 1 YES	2 X NO	If yes, spe	cify Cuban, Mexicar	IC ORIGIN? (Specify Ven, Puerto Rican, etc.)		RACE — American Indian, Black, White, etc.			
B	3 Widowed 4 □ Divorced	W YES, GIVE WAN ON D	mics .	1 1 125	2 NO Specify	•		SpecHy: White			
COMPLETED	15. DECEDENT'S ED (Specify only highest gree		16a. DECEDENT'S U (Give kind of wo	ork done during mos	N t of working	16b. KIND OF BU	SINESS/INDUST	RY			
Ë	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille. Do NOT use	retired.)		1					
OM IE	17. FATHER'S NAME (First, Middle, Last)		Homemake	er	48 MOTHED'S NAI	OWN  WE (First, Middle, Maiden					
S O	M.B. Sw	anson				inia Hudd					
D BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A	ADDRESS (Street ar		oute Number, City or Tox		Je)			
2	Dianne S. Conn		206 Ne	w Mark H	Esplanade	e, Rockvil	le, Ma:	ryland 20850			
E .	20e. METHOD OF DISPOSITION 1X Purial 2 ☐ Cremation 3 ☐ Re	moval from State Col	b. PLACE AND DATE OF	F DISPOSITION (Ner	ne of 3/23/9			City or Town, State			
Ĕ	4 Donation 5 Other (Specify)		petery, crematopy or other of He					ring, Maryland			
TO BE COM	21. SIGNATURE OF FUNERAL SERVICE L	JCENSEE 1/		Homo /D	O Classi 1 1 0	Robert	A. Pun	nphrey Funeral Montgomery Ave			
	Mulele =	1 Sulla	M00348	Rockvi	lle, Mar	vland 20	850-280	)5			
200	23. PART I. Enter the diseases, or shock, or heart failure	r complicátiona that cause s. List only one cause on e	d the death. Do no each line.	ot enter the mod	le of dying, such	aa cardiac or resp	iratory arrest,	Approximata interval Between			
	IMMEDIATE CAUSE (Final disease or condition							Onset and Death			
event,	cancer of the floor of the mouth  DUE TO (OR AS A CONSCOUENCE OF):										
		Tobacco a	,					20 years			
CERTIFICATION	Sequentially list conditions, if any, leading to immediate		A CONSEQUENCE OF)	:				20 years			
5	CAUSE (Disease or injury	C									
	that initiated events resulting in death) LAST	DUE TO (OR AS A	A CONSEQUENCE OF):	•							
CE S		d									
AL CE	PART II. Other aignificant condition	ons contributing to death t	out not resulting in	the underlying	cause given in I	Part I. 24a. WAS AN PERFO		24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO			
	Rectal Cancer					1 YES :	ON K)	COMPLETION OF CAUSE OF DEATH?			
AN: MEDIC						_		1 TYES 2 NO			
	25. WAS CASE REFERRED TO MEDICAL	T		20 04	CE OF PEATH OL	t and and					
YSICI	EXAMINER?  1  YES 2 NO	HOSPITAL:		OTHER:	CE OF DEATH (Che	6 Other (Specify)					
H Y	27. MANNER OF GEATH	28e. DATE OF INJURY	28b. TIME	OF 28c, INJU	RY AT	28d. OESCRIBE HOW	INJURY OCCURE	ED			
BY PH	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU		ES 2 NO						
	3 Suicide 6 Could not be	28e. PLACE OF INJURY building, etc. (Spe	f — At home, farm, str	reet, factory, office		26f. LOCATION (Street City or Town, State)	and Number or R	iural Route Number,			
ETE							<u></u>				
COMPLETED		SICIAN: To the best of my know									
8		NER: On the basis of examination	n and/or investigation,	, in my opinion, de	ath occured et the t	time, data and place, ar	nd due to the ca	use(s) and manner as stated.			
BE	296, SIGNATURE AND TITLE OF CERTIFI	ER			29c. LICENSE NUM	BER	N .	GNED (Month, Day, Year)			
P 2	10. HAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF DE	ATH (ITEM 27) /Tope 6	Print)	D26025	<u> </u>	Mar	ch 22, 1993			
	Jay S. Morrow,				#615 G=	i therehur	n. Mars	7land 20070			
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	IATURE		"OLJ, Ga	TUICEBUUL	g, Mary	Zuliu 200/9			
	MAR 24 '93	Julia Davids	andell.								

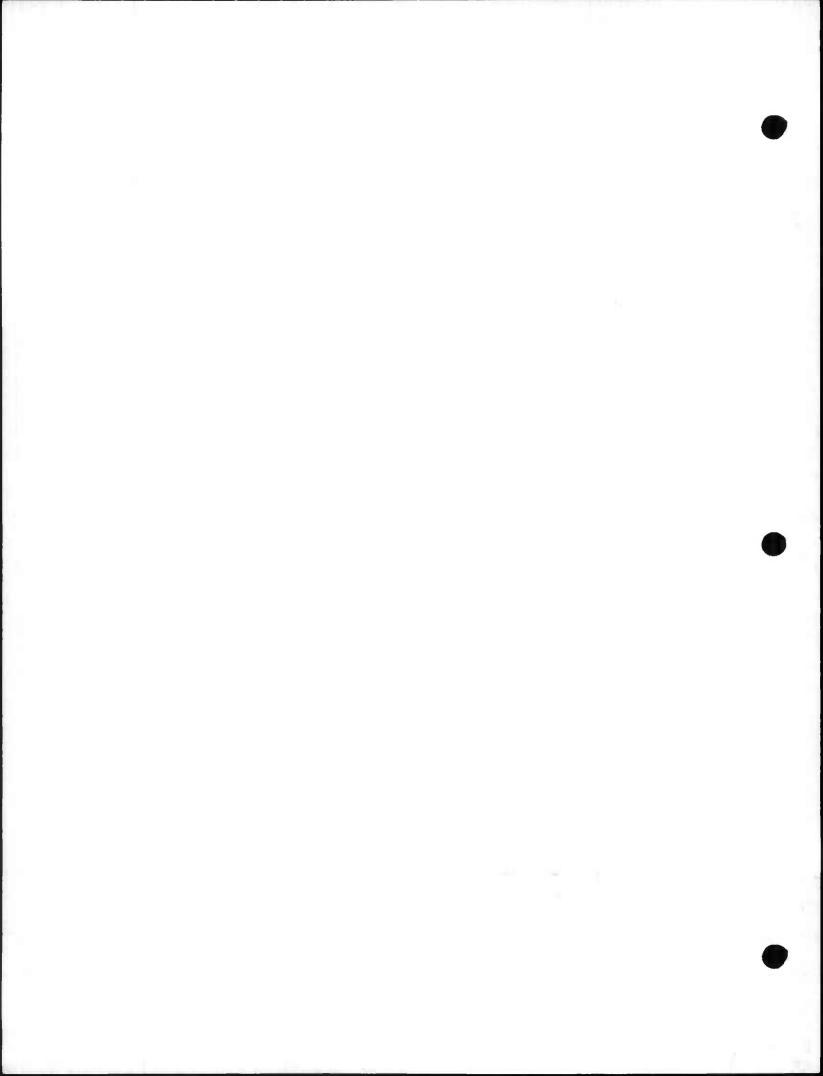


BALTIMORE, MARYLAND 21215-0020	NATIONING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  OFFICIAR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit.	e medical examiner must be notified at once.
<b>DIVISION OF VITAL RECORDS, P.O. BOX 68760,</b>	WATTINDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. OFFITINE After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transmin or removal.	item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

									REG. NO			
- 3	1. DECEDENT'S NAME (First, Middle, La	et)							2. DATE OF DEATH	00		3. TIME OF DEATH
	Juanita	Saulnier										
				3. AGE (In yrs. last birthday) IF UNDE					03/06/93		1:00 A.M.M	
1 1		_ x		7.2 YRS.		F UNDER 1 YEAR F UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)		
	093-12-5013 1□M2\(\text{\text{\$\infty}}\) 73				10				10/23/1	/23/19 Puerto		uerto Rico
	9a. FACILITY NAME (If not institution, gir	e street and number)			96. CITY, 1	96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DE						
00										100		
DIRECTOR	11600 Game Pr	eserve Roa	ıd		Gait	Gaithersburg Montgo					mery	
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2	in and the second										10d. INSIDE CITY LIMITS?	
											1 X YES 2 NO	
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FUNERAL	11600											
ᄬ	11600 Game Pre	serve Road				20	0878			Uni	ted S	States
5	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S	ARMED	13. W	AS DECEN	DENT OF H	IISPAN	IC ORIGIN? (Specify Yes	or No-	14. RACE	- American Indian,
	1 Never Married 2 Married	FORCES? 1	MR OR DATES	XMO			ly Cuben, I NO		n, Puerto Rican, etc.)			t, White, etc.
B	3 Wildowed 4 Divorced	120, 0.112 /	- III OII ONI ES		1 '2	T ica i			to Rican		Speci	Latin
0	15. DECEDENT'S E	DICATION	- 10					uc.				000211
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	Elementary/Secondary (0-12)	College (1-4 or 5 :	•)	IIIe. Do NOT us	e retired.)							
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6	17. FATHER'S NAME (First, Middle, Last)						A. MOTHER	'S NAI	ME (First, Middle, Malden			
	11-1									OUT HEITHEY		
出	Unknown			·			Unk					
2	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS (	Street and i	Number or	Rural R	loute Number, City or Town	n, State, Zi	ip Code)	
=	Baiyina Sharif			11600	Cama	Prac	arva	D.	oad, Gaith	orah	1120	MD 20070
	20a. METHOD OF DISPOSITION		1 000 01 0	CE AND DATE				N				
	1 🗇 Buriel 2 🗆 Cremation 3 🕅 R	emoval from State	cemetery	crematory or o	ther place!						- City or To	
	4 🗀 Donation 5 🗆 Other (Specify) _		Long	: Islar	nd Nat	:'1 0	Cem.		3/11/93 P	inel.	awn.	NY
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE	7				ADDRESS					
	Hause	111	Kuie		Co.	lonia	al Fu	inei	ral Home			
	C alune			_	616	51 Le	esbu	ırg	Pike, Fal	ls C	hurch	n, VA 22044
	23. PART I. Enter the diseases, of	r complications that	t caused the	death. Do r	not enter ti	ne mode	of dying	suct	as cardiac or resol	ratory as	mest.	Approximata
	shock, or heart failui	e. List only one ceu	se on each	line.				,			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Interval Between
	IMMEDIATE CAUSE (Finel											Onset and Death
1 1	disease or condition resulting in death)  Metastatic Carcinoma of the Lungs  DUE TO (OR AS A CONSEQUENCE OF):											0
1 1												
	resulting in death)	a. DUE TO	(OR AS A CON	NSEQUENCE OF	F):	JI LI						8 mos.
12	resulting in death)	DUE TO	(OR AS A CON	NSEQUENCE OF	F):	JI LI						8 mos.
n NO	Sequentially list conditions,	оиє то ь. <u>Hyper</u>	corasacoa ctensio	NSEQUENCE OF	F):	JI (I						8 mos.
ATION	Sequentially list conditions, if any, leading to immediate	оиє то ь. <u>Hyper</u>	corasacoa ctensio	NSEQUENCE OF	F):	)I (I						8 mos.
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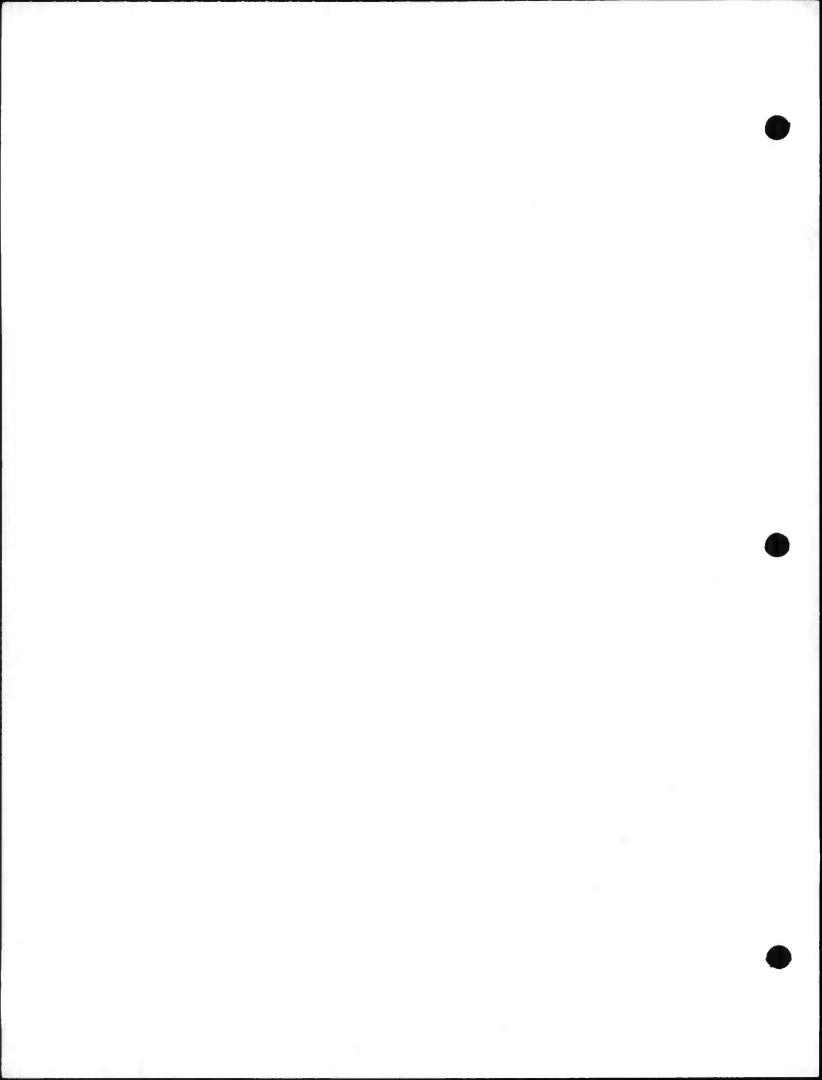
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IN THE HARENAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Memal Hygiens prior to burial, cremation, or removal.

IMPORTANT: It liem 28 is marked, or flem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CER	TIFICA	TE OF	DEATH	RI	EG. NO.					
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF D	EATH			3. TIME OF D	EATH	
	ANNE	REA		MARCH 22, 19			93	7:51	Α.	м			
	4. SOCIAL SECURITY NUMBER	5. SEX 6. A	GE (in yrs. lest birt		DER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF B	HTH		6. BIRTH	IPLACE (State o		,
	184-14-8358	1 ☐ M 2 💢 F	1 M 2 M F 81 YRS. MONTHS DAYS HOURS MIN. (Month, Day, Year)							Countr	y) RGINIA		
	9a. FACILITY NAME (If not institution, give s	treet and number)		9b. C	TTY, TOWN	OR LOCATION OF D				NTY OF D			= 5
O.	321 UNIVERSITY BOULEVARD WEST, #333 SILVER SPRING MONTGOME												
5	RESIDENCE OF DECEDENT												
DIRECTOR			10								10d. INSIDE C	YTE	
	MARYLAND MON	TGOMERY		SILVI	ER SP	RING					1   YES 2	□ NO	
RAI					10	f. ZIP CODE			10g, CITI	ZEN OF W	WHAT COUNTRY	77	
FUNERAL	321 UNIVERSITY E					2090			υS	A			
	11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEDENT EVE FORCES? 1 \( \subseteq \text{ Y}	ER IN U.S. ARMED		13. WAS DEC	CENDENT OF HISPAI ecify Cuban, Maxica	NIC ORIGIN? (Sp.	ecify Yes	or No-	14. RACE Black	— American I	ndlan,	
B	3 XWidowed 4 Divorced	IF YES, GIVE WAR O	R DATES			2 NO Specif			l	Spech	ty:		
	15. DECEDENT'S EDU		16a, DECED	ENT'S USUAI	OCCUPATI	ON	165 KIME	OF BUILD	INESS/IND	HIGTON	WHITE		_
	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Give ki	ind of work do NOT use retire	ne during mo	est of working	TOLK KING	OF 803	INESS/IND	USIRI			
P.	Everyone in the control of (0-12)	College (I-4 or 5+)	HOME	MAKER									
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			MICEIC		18. MOTHER'S NA	MF (First Middle	Maiden	Cumamai			_	
	EUGENE MERR	RITT REA	٨						1				
BE	19a. INFORMANT'S NAME (Type/Print)	TII KE		AILING ADDR	ESS (Street	ANNA and Number or Rural	MAE R			Codel	-		_
2	MARY ANNE FRYE												
	20a. METHOD OF DISPOSITION		20b. PLACE AND			KLIN AVEN	DATE		SPR PATION —			901	
1	1 Donation 5 Other (Specify)	oval trom State	METROP(	OT. TTAN	CREN	MATORY	3/22						
	21. BIONATURE OF FUNERAL SERVICE LIC	ENSEE //			22. NAME A	ND ADDRESS OF FA	CILITY						
	5/1/2/	17.116.6	_	E	RANC	IS J. COI	LINS F	UNER	ALH	OME,	INC.		
$\neg$	23. PART 1. Enter the diseases, pro	complications that can	sed the death	Do not an	tor the me	NIVERSITY	t PLVD.	, W.	, SI	L. S			90
	snock, or near tellure.	List only one ceuse o	n eech line.	DO HOL GII	ter the mo	de Di dying, suc	n es cardiec [	or respii	atory arr	est,	Approx	Betwe	
H											Onset a		
	resulting in death)				addes	care	noma				7 17	10 uty	15
-	DUE TO (OR AS A CONSEQUENCE OF):										İ		
CERTIFICATION	Sequentially liet conditions, If any, leading to immediate  DUE TO (OR AS A CONSEQUENCE OF):									<u> </u>			
8	cause. Enter UNDERLYING												
E	CAUSE (Disesse or injury that initiated events	DUE TO (OR /	S A CONSEQUEN	ICE OF):							1		
E	resulting in deeth) LAST	d											
	PART II. Other significant condition	s contributing to deet	h but not resul	ting in the	underlyin	A Course observed in	Part I are	MM C 411	I PROBLEM	1			
PHYSICIAN: MEDICAL		- obminating to door	II DOL IIDE TOSOI	ung in the	dildellyin	y ceuse given in		PERFOR	MED?		WERE AUTOPS!	OT RC	
							_   10	YES 2	NO NO		OF DEATH?	+ CAUSE	
Σ							-				1   YES 2	NO	
A	25. WAS CASE REFERRED TO MEDICAL												_
S	EXAMINER?	HOSPITAL:		ОТН	ER:	ACE OF DEATH (Ch							$\dashv$
¥	27. MANNER OF DEATH	1   Inpetient 2   ER/C		b. TIME OF	fursing Hom 28c, INJ	e 5 Residence							
	1 Natural 5 Pending	(Month, Day, Yea		INJURY	wo	RK?	28d. DEŞCRIBI	E NOW IN	JURY OCC	URED			
B≼	2 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF INJU	JRY At home 1				204 1 00471011	(04		0 10			-
	4 Homicide 8 Could not be determined	building, etc. (5	Specify)		actory, onic		28f. LOCATION City or Tow	n, State)	na Number	or Hunel H	oute Number,		
9	29a, CERTIFIER												_
COMPLETED	(Check only 1 CERTIFYING PHYSIC												
8		R: On the basis of exemina	ition and/or invest	tigation, in m	y opinion, d	eath occured at the	time, data and p	elaca, and	dua to the	e cause(s)	and manner a	stated.	
BE	296. SIGNATURE AND TITLE OF CERTIFIER	le DO	mO			29c. LICENSE NUN					(Month, Day, Ye	nr)	
2	20 NAME AND ADDRESS OF PERSON	O COMPLETE				D 3516	, _		3	155	2/93		
	30. NAME AND ADDRESS OF PERSON WHO	NOUR M		(Type, Print)	RINA	STREE	T SIL	VER	SPR	IMG Y	no 700	110	$\Box$
	31. DATE FILED (Month, Day, Year)				17110	21116.6	, 31-	- 101	3111	.,	10 20	110	
	MAR 25 '93	102 REGISTRAR'S SI	and all										



FOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

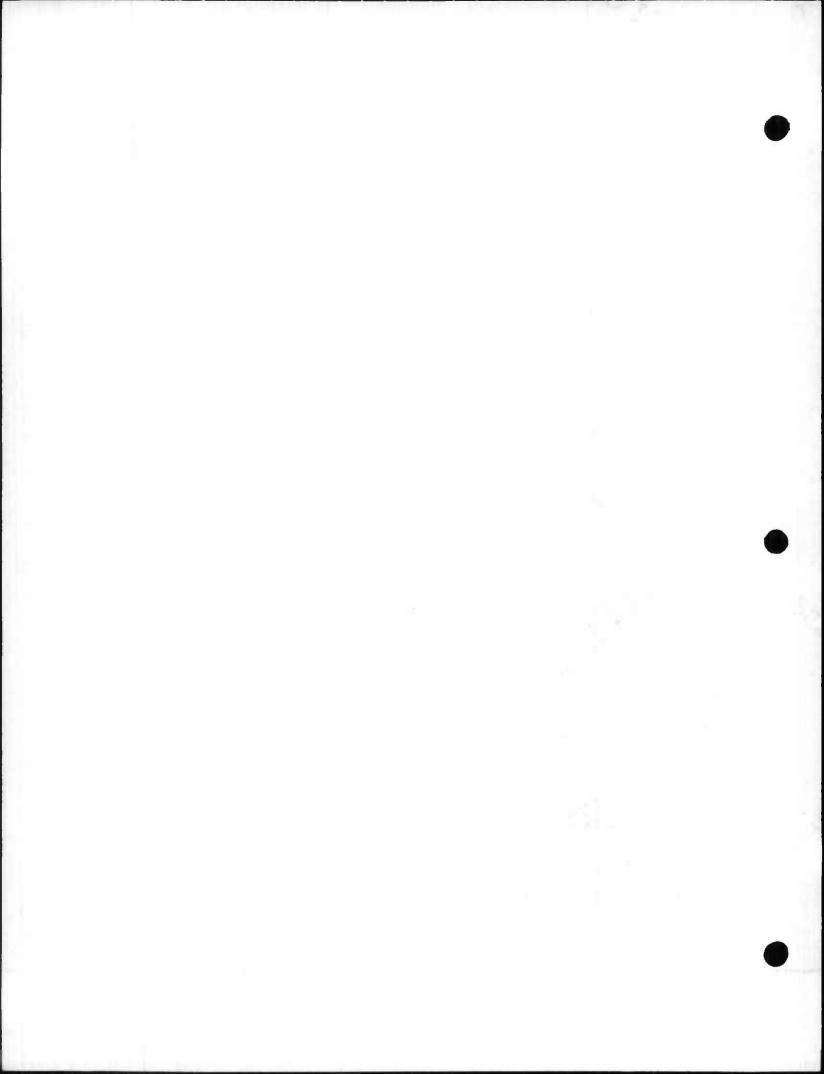
	Sician.	ial-transit permit. Pages 1, 2, 3 sh		
	MSICIAN: The law requires that the death certificate be executed within 24 flours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buria-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hydiene order to burial. cremation, or removal.	e notified at once.	
	rs after death. Page 6 may	by the funeral director, pagremoval.	dical examiner must be	
6	te be executed within 24 hour	LINERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral minim 72 hours after death with the State Dept. of Health and Mental Hydiene prior to burfal, cremagion, or removal	1, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
	quires that the death certifica	signed by the attending phy Health and Mental Hydlene	ows any injury, or other	The second second second
	ING PHYSICIAN: The law req	After this certificate has been leath with the State Dept. of	marked, or item 23 she	
	THE ROSPITAL OR ATTENDING PHYSI	THE LINERAL DIRECTOR; After this of the thing of the thin	ORTANT: If item 28 is	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCICALS

	1 - STATE REGISTRAR		CEI	RTIF	ICATE O	F DEAT	TH		REG. NO			
	1. DECEPITY'S NAME (First, Middle, Last)					2. DATE OF MONTH	DEATH	DAY YEAR		3. TIME OF OEATH		
	M		SCHLESINGER						20	93		
ą.		SEX 6.	AGE (In yrs. lest b	YRS.	MONTHS DAYS	-	MIN.	7. DATE OF (Month, D	lay, Year)	1024	Countr	PLAČE (State or Foreign V) NSYLVANIA
1	9e. FACILITY NAME (If not institution, give stree	t end number)			96. CITY, TOWN	OR LOCATION			JI, .	-	INTY OF D	
DIRECTOR	SUBURBAN HOSPITAL					THESD				10.0	NTGO	
EC	10e. STATE 10b. COUNTY			10c. CIT	Y, TOWN OR LOC	ATION						10d. INSIDE CITY
	MARYLAND MONTGO	OMERY			OTOMAC							LIMITS?
M	10e. STREET AND NUMBER					of. ZIP CODE				10g. CIT	IZEN OF W	HAT COUNTRY?
EF	11910 COLDSTREAM DE	RIVE			1	208	54			UNI	TED	STATES
BY FUNERAL	11. MARITAL STATUS  1	PORCES? 1 TO IF YES, GIVE WITH	VER IN U.S. ARME YES 2 NO OR DATES	ED	If yes,	ECENDENT Of the second	n, Mexicar	IC ORIGIN? (5 n, Puerlo Rice	Specify Ye	e or No—	14. RACE Black Specif	— American Indien, , White, etc. y: WHITE
8	15. DECEDENT'S EDUCAT	ION	16a. DECE	DENT'S	USUAL OCCUPA	TION		16b. KI	ND OF BU	SINESS/IN	DUSTRY	
E	(Specify only highest grade con Elementary/Secondary (0-12)	npleted) College (1-4 or 5+)	(Give	kind of w	vork done during i e retired.)	nost of workin	g					
P		5+	ENG	INE	ER			υ.	.s. (	GOVER	NMEN'	T
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTH	IER'S NAI	ME (First, Midd	dle, Maiden	Sumame)		
BE (	SAM SCHLESINGER					RO	SE	ISAA	CS			
10	19a. INFORMANT'S NAME (Type/Print)		19b. I	MAILING	ADDRESS (Stree	and Number	or Rural R	loute Number,	City or Tow	n, State, Zij	p Code)	
۴	JEANNE SCHLESINGER 200. METHOD OF DISPOSITION	(WIFE)			COLDSTR		RIVE	<del></del>				
	1 X Buriel 2 Cremetion 3 Remova 4 Donation 5 Qther (Specify)			PER DISPOSITION (		NS.	3/22 OLNEY, MARYLAND					
	21. SIGNATURE DE FUNERAL BERRES LICENS	SEE	000		22. NAME	AND ADDRES	S OF FAC	HLITY				
	and to tag	a						BERG N PIKE,				ELS, INC. MD 20852
T	23. PART I. Enter the diseases, pr com	plicationa that ca	used the deat	h. Do n	ot enter the m	ode of dvi	ng. auch	as cardiac	or men	iratory ar	rest.	Approximate
	ahock, or heert fallure. Lie  IMMEDIATE CAUSE (Final diseese or condition reaulting in death)	CARD	on each line.									Interval Between Onset and Death
	rounding in doubly	DUE TO (OR	AS A CONSEQUI	ENCE OF	7):							
CERTIFICATION	Sequentially list conditions, SEPTIC SHOCK										_	
Ĭ.	if any, leading to immediate cause. Enter UNDERLYING	PCEUM	AS A CONSEQUE	CF	DAPIAE	· 0V6	PL/IX	E) MIN	6 1	NFG	CTION	1
띮	CAUSE (Disease or Injury that initiated events	OUE TO (OR	AS A CONSEQUE	ENCE OF	7):	- OVE	Jean He		0 1	/ / 1 /	-11011	V
F	resulting in death) LAST	IS EUDON	MINA	CER	ACIAE	PNE	UM	ONIA				1
DICAL	PART II. Other algorificant conditions of	ontributing to dea	ith but not rea	uiting i	n the underlyl	ng cause g	Iven in F	Part I. 24	a. WAS AN PERFOR	AUTOPSY RMED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
ă	BLOHT CORTICAL C	EKEDKAL	- 1102416		H11KV4	L+10	RILL	4JION,	YES 2	NO		COMPLETION OF CAUSE OF DEATH?
M	CHRONIC LEUKOC	410515	NON-IV	ISUZ	IN DE	PENDI	ENT					1 - YE\$ 2 - NO
ä	DIAGETES MELLI	NS, HY	PERTEN	15/0	N, ASP	1RA-TO	IN 71	NEUNO	NIA			
PHYSICIAN: ME	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:			OTHER:	PLACE OF DE	ATH (Che	ck only one)				
XS		Inpetient 2 - ER			4 🗆 Nursing Ho		sidence (	6 Other (S	pecify)			
	27. MANNER OF DEATH  1. Neturel 5 Pending	(Month, Day, Y		BMIT .d8!	URY V	JURY AT		28d. DESCRI	IBE HOW I	NJURY OC	CURED	
B	2 Accident Investigation	24- BLACE OF IN	HIPM AAA	4		YES 2	NO					
COMPLETED	3 Suicide 6 Could not be 4 Homicide determined 28. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 288. PLACE OF INJURY — At home, ferm, street, factory, office City or Town, State) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)									oute Number,		
닐	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAL	N: To the best of my	knowledge, death	occume	d at the time, de	te end nince	and due	to the course	e) and ma	anar na ata	and a	
OM	(Check only one)  2 MEDICAL EXAMINER: C											end manner es steted.
	200. SCHATURE AND TITLE OF CERTIFIER					29c. LICE	NSE NUM	BER		29d. DAT	E SIGNEO	(Month, Day, Year)
BE	OM Mary MD	)				102	65=	71	MD	▶ 3	201	93
임	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETEO CAUSE O	F DEATH (ITEM 2	7) (Type,	Print)	^			_		1 - 1	1-
	IRVING MIZUS, MD		EDARL	AN!	=#201	C	ETHE	50A,1	MD	208	14	
	31. DATE FILEO (Month, Day, Year)  MAR 22 202	32. REGISTRAR'S	SIGNATURE	nd . 90								

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2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH YEAR P WALTER RAYMOND SCEERY MAR 1993 2:45 17 7. DATE OF BIRTH (Month, Day, Year) A SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR B. BIRTHPLACE (State or Foreign IF UNDER 24 HRS 1 📈 M 2 🗌 F VPS APR 12 049-09-0881 1919 CONNECTICUT permit. Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution, give 9h. CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR NATIONAL NAVAL MEDICAL CENTER **BETHESDA** MONTGOMERY 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 YES 2 NO MARYLAND MONTGOMERY POTOMAC FUNERAL 10e. STREET AND NUMBER INF ZIP CODE 10g. CITIZEN DF WHAT COUNTRY? use as the burial-transit 10307 RIVERWOOD DRIVE 20854 UNITED STATES within 24 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 2 NO 1 Never Married 2 Marrie 1 TYES 2 NO Specify BY Specify 3 Widowed 4 Divorced 1957 - 1987 WHITE COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe 10 Elementary/Secondary (0-12) College (1-4 or 5+) Social Worker/Lawyer U.S. Public Health Service detached 5+ once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) the funeral director, page 5 should be 75 8 EDWARD JOSEPH SCEERY ALICE MARY WELSH notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 REVERLY DAVIS SCEERY 10307 RIVERWOOD DRIVE, POTOMAC, MD 20854 9 20a. METHOD OF DISPOSITION
1 □ Burlal 2 ② Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 3/19/93 DATE 20c. LOCATION - City or Town, State must Montgomery Crematorium, Inc. Bethesda, Maryland 4 Donation 5 Other (Specify) ROBERT AND ADDRESS OF FACILITY
ROBERT A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc.
7557 Wisconsin Ave., Bethesda, MD 20814-3501 examiner 21. SIGNATURE OF FUNERAL BERVICE LICENSEE M00198 alu torruh or removal. the medical HAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by in The row arm death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remo 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximata shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) ESOPHAGEAL CANCER event, DUE TO (OR AS A CONSEQUENCE OF): executed traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate DUF TO (OR AS A CONSEQUENCE OF) death certificate be Cause Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (DR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 20 shows any injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 1 TYES 2 NO OF DEATH? 1 TYES 2 T NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL E P 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: OFFITTENDING PHYSICIAN: 1 TYES 2 NO 1 Srinpatient 2 - ER/Outpatient 3 - DOA e 5 ☐ Residence 8 ☐ Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 28 is marked, 1 X Natural 5 Pending 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be determined COMPLETED 4 Homicide 29a. CERTIFIER (Check only 1 💢 CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) MD 18 Mar 93 PRE 2 30. NAME AND ADDRESS OF PEASON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NATIONAL NAVAL MEDICAL CENTER SUPINSKI. LT. MC. USNR BETHESDA MD 20889-5600 32. REGISTRAR'S SIGNATURE 31. DATE FILEO (Month, Day, Year) while Davidson Bordell ,03 MAR 2



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

BE COMPLETED

2

4 Homicide

												3.	3	19116	)
	1 - FOR STATE REGISTRAR		STATE OF N	MARYLAN	D / DEPAI CERTIF	RTMEN	T OF H	DEA	AND I	MENTAL	HYGIEN	_			
	1. DECEDENT'S NAME (First,	Middle, Last)								2. DATE OF DEATH				3. TIME OF DEAT	Н
	John			Τ	ewis	C	Smit	h		MONTH 0.3		6 19	YEAR	0 - 2 -	D .
	4. SOCIAL SECURITY NUMBER	ER	5. SEX		s. last birthday)		IF UNDER 1 YEAR		7 24 HRS.	7 DATE (	C BIOTH			8:35 PLACE (State or Fo	
	577-04-8161		1 K M 2 - F	18	YRS.	MONTHS		HOURS	MIN,	(Month, Apr	Day, Year) 23,	1975	Country	Vash., D	. C .
	9a. FACILITY NAME (If not ins	titution, give si	reet and number)			9b. CIT	Y, TOWN	OR LOCATI	DN OF O	EATH		9c. COU	NTY OF D		
DIRECTOR	Easton Memorial Hospit			pital		E	ast	on		Talb				ot	
ĕ	10a. STATE	10b. COUNTY	,		10c. CI	TY, TOWN	OR LOCAT	TION			-			10d. INSIDE CITY	
5			-		Wa	shin	gton	, D.	C.					LIMITS?	NO
A L	10e. STREET AND NUMBER						-	, ZIP COD				10g. CIT	IZEN OF W	HAT COUNTRY?	
FUNERAL	2424 Tracy	Place,						200	80				USA		
BY	11. MARITAL STATUS  1 Never Married 2   1  3   Widowed 4   Divor		12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2	XNO	13.	It yes, sp	ENDENT ( ocify Cube 2 \( \text{LNO}	in, Mexica	n, Puerto R	(Specify Yes	or No—	14. RACE Black Specif	- American India , White, etc. y: White	ar),
	15. DECE	DENT'S EDUC	CATION	164	DECEDENT'S	USUAL C	CCUPATIO	ON		16b.	KIND OF BU	SINESS/INI	DUSTRY		
COMPLETED	(Specify only highest grade completed)  Elementary/Secondary (0-12)  1 2  Cotlege (1-4 or 5-			)	(Give kind of life. Do NOT u	se retired.)	) during mo	st of worki	ng		Schoo	1			
× I	17. FATHER'S NAME (First, Mic	Dec													
	John Lewis Smith  18. Mother's NA  Marjor:									Sumame)					
H	19a. INFORMANT'S NAME (Type/Print)  19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)										_				
5	John Smith, III 2424 Tracy Pl., NW, Was										0008				
	20s. METHOD OF DISPOSITION 1 AL/Burlel 2 Cremetton 3 Removal from State 4 Donatton 5 Other (Specify)				ACEAND DATE OF DISPOSITION (Name of Crematory of other place)  Commator of other place  Commettery					3/20 Washington, D.C.					
	21. SIGNATURE OF FUNERAL	-	ENSEE			22. NAME AND ADDRESS OF FACILITY Joseph Gawler's Sons, In						Shington, D.C.			
	miel	0.0	& Ma	Da-							Sons, Inc. Ave, NW, Washington, DC 20016				16
	23. PART i. Enter the dis	eases, or c	omplications the	caused the	death. Do	not ente	r the mo	de of dy	ing, auc	h se cerdi	ac or reap	ratory an	reat.	Approxima	
	ahock, or he iMMEDIATE CAUSE (Fine disease or condition	ert fallure. I	List only one cau	se on each	iine.			,					,	intervei Be Onset and	tween
	resulting in death)  a. Condia. archythmia  Due TO (DR AS A CONSEDURACE DF):											-			
-			Antic	STA	- 4	.,								j	
TIO	Sequentially list conditions, If any, leading to immediate  b. MOVIC SUM 0518  DUE TO (DR AS A CONSEQUENCE DF):														
FICA	cause. Enter UNDERLYIN CAUSE (Disease or injur		DUE TO	OD AS A CO	NSEDUENCE D	5.									
CERTIFICATION	that initiated events reaulting in death) LAST		l	(011 A3 A CO1	ISEOVERICE D	r).									
	DADT il Other significan	t condition		d01 b0											
3	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part  Down's Syndrome									24a. WAS AN PERFOR	MED?		WERE AUTOPSY FIN AMAILABLE PRIOR 1 COMPLETION OF C	TO	
AED I		- 1/11/00				-				-	1 X YES 2	□ NO		OF OEATH?	
ä										_				1 X YES 2 N	
SA	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	Hooping					ACE OF D	EATH (Che	ock only one	)	-			
<u>s</u>	17 YES 2 NO		HOSPITAL:	ER/Outpatier	R 3 DOA	OTHE 4 - Nu		• 5 🗆 Re	rsidence	6 🗆 Other	(Specify)				
BY PHYSICIAN: MEDICAL	27. MANNER OF OEATH  1 Netural 5 P		28a. DATE DF (Month, De	INJURY ay, Year)	26b. Till IN.	_	28c. INJ WO				RIBE HOW I	NJURY OC	CUREO		
6	2 Accident	vestigation	20- 01-005-01			-									

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 YES 2 - NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. DATE DF INJURY (Month, Day, Year) 27. MANNER OF OEATH 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCUREO 1 Natural
2 Accident 1 YES 2 NO 26a. PLACE DF INJURY — At home, farm, atraet, factory, offica building, etc. (Specify) 6 Could not be determined 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide

29s. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, and due to the cause(a) and manner as stated.

2 MEDICAL EXAMINER: On the beals nation end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

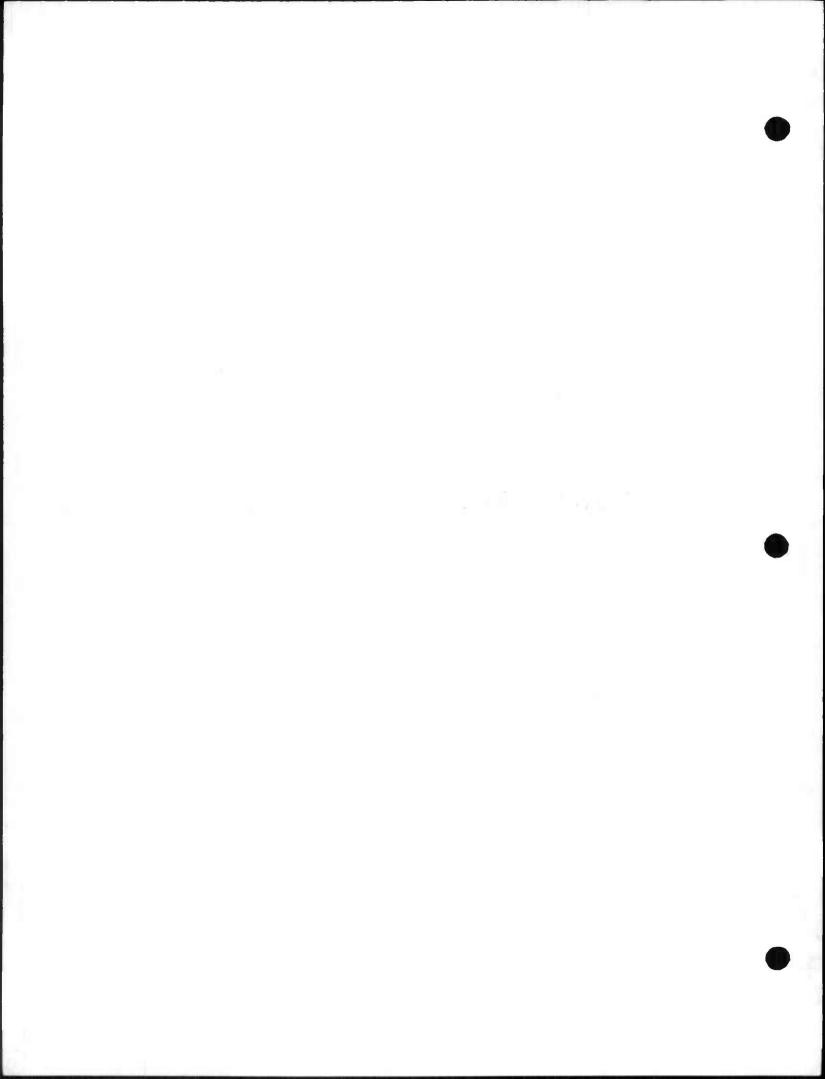
O.C.M.E.

29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

DONALD G. WRIGHT, M.D. 111 Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, MAR 22 32. REGISTRAR'S SIGNATURE **\*9**3 Ronde BL 03/18/1993



DIVISION OF VITAL RECORDS,
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31. DATE FILED (Month, Day, Year)

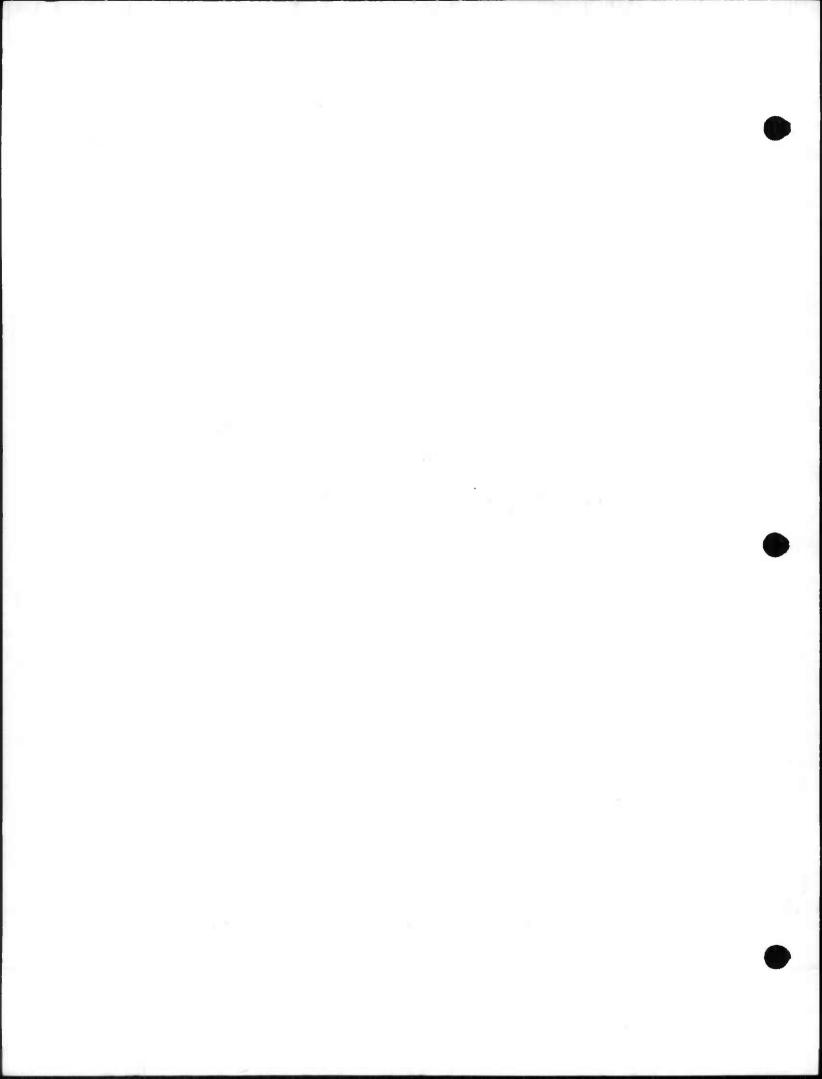
32. REGISTRAR'S SIGNATURE lia Davidson

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) Margaret E. Sugrue E. SUGRUE 2. DATE OF DEATH 3. TIME OF DEATH 1993 largare March 4. SOCIAL SECURITY NUMBER B. AGE (In yrs. last birthday, 7. DATE OF BIRTTH (Month, Day, Year)
July 16,1913 IF UNDER 1 YEAR IF UNDER 24 HRS B. BIRTHPLACE (State or Foreign DAYS HOURS 1 😾 M 2 🗌 F 577-07-2930 79 YRS detached for use as the bunial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR Suburban Hospital Bethesda Montgomery 10c. CITY, TOWN OR LOCATION Chevy Chase 10a STATE 10b. COUNTY 10d. INSIDE CITY MD Montgomery 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 20815 USA 7108 Lenhart Drive 24 hours after death. Page 6 may be retained by the hospital or attending physician. filled in by the funeral director, page 5 should be detached for use as the bunial-tran 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-11. MARITAL STATUS 14. RACE — American Indian, Black, White, atc. If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 N Married Specify: White BY 3 Widowed 4 Divorced 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Harry B. Kanode notified at Essie Mae Lenhart BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code 9 Bernard A. Sugrue 7108 Lenhart Dr., Chevy Chase, MD must be 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Gate of Heaven Cemetery 3/20 Silver Spring, MD 4 Donation 6 Other (Specify) medicai examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph Gawler's Sons, Inc. 6 5130 Wisconsin Ave, NW, Washington, DC 20016 this certificate has been signed by the attending physician and completely filled in by the with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiec or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line. interval Batween **IMMEDIATE CAUSE (Fine)** Onset and Death the disease or condition death certificate be executed within event, resulting in death) traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other that initiated eventa resulting in death) LAST 10 injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 34s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE shows any I HES 2 X NO 1 YES I NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? 1 ☐ YES 2 ☑ NO HOSPITAL OTHER: tient 3 [] ER/Outpo Clent 3 DOA ne 5 🗆 Residence 6 🗆 Other (Specify) 10 27. MANNER OF DEATH 26s. DATE OF INJUSTY (Month, Day, War) 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 28 is marked, 1 X Natural 5 Pending 1 YES 3 NO BY After 2 Accident 3 Suicide 28s. PLACE OF INJUSTY — At home, farm, street, fectory, offic building, etc. (Specify) 281, LOCATION (Titriet and Number or Rural Route Number, City or Team, State) COMPLETED 6 Could not be DIRECTOR: / 4 Homicide Hem 29e. CERTIFIER

(Chart only

1 DEERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. FUNERAL ( = 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. MPORTANT: 296. SIGNATURE AND TITUE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) HE 0574 117 28 2 ERSON WHO COMPLETED ONUSE OF DEATH (ITEM 27) (Type, Print) Stephen N. Jones, M.D.,



FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATN YEAR WILLIAM SMIRO LDO 03 1993 12:00 PM JR. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTN (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Country) 218-76-9833 1 XM 2 7 F 33 MONTHS DAYS 6-26-1959 Rhode Island nours after death. Page 6 may be retained by the hospital or attending physician. ed in by the tuneral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9s. FACILITY NAME (if not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR PRINCE GEORGES HOSPITAL CHEVERLY PRINCE GEORGES RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. St. Mary's Hollywood 1 - YES 2 X NO FUNERAL 10a. STREET AND NUMBER 10t. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Rt 2, Box 376 20636 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES A WAS DECEMBENT OF NISPANIC ORIGIN? (Specify Yee or NoIf yee, specify Cuban, Mexican, Puerto Ricen, etc.)
 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Merried 8 Specify: 3 Widowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) ntary/Secondery (0-12) College (1-4 or 5+) Steamfitter #602 Union 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) William Smiroldo, Sr. ¥ Lorna Peirce BE notified a 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) William Smiroldo, Sr. Rt 2, Box 376 Hollywood, Md. 20636 pe 20e. METHOD OF DISPOSITION
1/1 Burlel 2 Cremation 3 Removal from State
4/2 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must 3/25 Waldorf, Md. off of the Menter Gdns medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY The Hyptt 150, ewal derre, Manc 20604 M00658 completely filled in by the I rial, cremation, or removal. 23. PART I. Enter the diseases, or complications that caused the death. Do not antar the mode of dying, such as cerdiac or respiratory arrest, Approximate shock, or heart fellure. List only one cause on each ilne. Interval Batween IMMEDIATE CAUSE (Final Onset and Death HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filler within 72 hours after death with the State Dept. of Health and Mental Hygiens prior to burial, cremation, within 72 hours after traumatic event, the STANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the disease or condition OUE TO (OR AS A CONSEQUENCE OF): resulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760, CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events QUE TO (OR AS A CONSEQUENCE OF) resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. MEDICAL 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24a, WAS AN AUTOPSY 1 YES 2 NO HERAD 1 YES 2 | NO 5192 PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) HOSPITAL OTHER: TYPES 2 - NO 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Nome 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending Investigation SELF-INFLICTED GUNSHOT 6:30P 8 1 YES 2 X NO 03/20/1993 2 Accident WOUND 3 X Suicide
4 Homicide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) ROWTEN. Street and Number or Rural Route Number. ROWTEN. Street. BOX #3/6 COMPLETED 6 Could not be AT HOME HOLLYWOOD, MARYLAND 2063 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. TO THE HOSPITAL OF THE FUNERAL DE BE FIED WITHIN 72 H (Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(e) end manner as stated. 29c. LICENSE NUMBER 29d. OATE SIGNED (Month, Day, Year) BE O.C.M.E. 03/23/1993 9 PLETED CAUSE OF OEATN (ITEM 27) (Type, Print) Penn Street, Baltimore, Maryland

**''**93

MAR 29

32. REGISTRAR'S SIGNATURE

Felia Davidson

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TOPECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit	Z hours after beath with the state befor, of Health and Mental Hyplene prior to burial, cremation, or removal.	f from 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
IG PHYSICIAN: The	er this certificate	am with the State	narked, or item
OR ATTENDIA	L DIRECTOR: Af	Z hours after de	f item 28 is r

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permit. Pages 1, 2, 3 should

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH OUISE Dorothy SCHMIDT 23.00% 25 03 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX 7. DATE OF BIRTH 12/16/1913 e. BIRTHPLACE (State or Foreign Country) Italy IF UNDER 1 YEAR IF UNDER 24 HRS. 215-09-1642 79 DAYS HOURS 1 M 2 1 F 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH HOSP County Gen DIRECTOR Carroll Stanin Prow Carroll RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10b. COUNT 10d. INSIDE CITY Finksburg Maryland Carroll 1 YES 2 KNO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2007 Brown Road 21048 USA 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 — YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 2 X NO 1 Never Married 2 Married BY White 3 🕅 Widowed 4 🗌 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple Elementary/Secondary (0-12) College (1-4 or 5+) Bookkeeper 12 John J. Roker Inc. be notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Dominic Sartori Katherine BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Thomas E. Schmidt 2007 Brown Road, Finksburg, Maryland 21048 20s. METHOD OF DISPOSITION
1 (ABurlai 2 Cremation 3 Removal from Stata
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Meadowridge Memorial Park 3/29/93 Baltimore, Md. 22. NAME AND ADDRESS OF FACILITY
Eckhardt Funeral Chapel 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gath 11605 Reisterstown Rd., Owings Mills, Md. 23. PARTY. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line interval Between Onset and Death IMMEDIATE CAUSE (Fine) disease or condition Sepsin (wik. reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): Renal Solute IWb CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING Iransitional cell Cancer Rt Urefer CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to deeth but not reaulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL Villion adenoma Item 23 shows any Colon 1 | YES 2 | NO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 -NO 1 Inflatient 2 ER/Outpetient 3 DDA 4 Aursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. be filed ment 72 ho IMPORTANT: If It 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Mer wo la 25 141097 193

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2 REGIS RAD SIQUE

Carroll County

30. NAME AND ABORDSS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHAWLA

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T	opposition and
212	the last no
<b>LAND 21215</b>	the hoen
MARYLA	P.
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BALTIMORE,	eath Par
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burial-transit permit, Pages 1, 2, 3 should

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IMPORTANT: If Item

Bed 223 CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE

2

DIRECTOR

FUNERAL

ΒY

COMPLETED

BE notified

2

17101 Clear Creek

(Specify only highest

20a, METHOD OF DISPOSITION
1 № Burlet 2 □ Cremation 3 □ Removal from State

21. SIGNATURE OF PUNERAL SERVICE LICENSEE

15. DECEDENT'S EDUCATION ecity only highest grade completed)

1 Never Married 2 Merried

Elementary/Secondary (0-12)

17. FATHER'S NAME (First, Middle, Last)

19e. INFORMANT'S NAME (Type/Print)

4 Donation 5 Other (Specify)

Sequentially ilst conditions, if sny, leading to immediate

cause. Enter UNDERLYING CAUSE (Disease or Injury

25. WAS CASE REFERRED TO MEDICAL

5 Pending

8 Could not be

EXAMINER?

27. MANNEY OF DEATH

1 Netural

2 Accident

3 Suicide

4 🗌 Homicide

disesse or condition

resulting in death)

that initiated events resulting in death) LAST

William Simpson

Harry Port

3 Widowed 4 Divorced

11. MARITAL STATUS

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

5 should page director, funeral signed by the attending physician and completely filled in by the I Health and Mental Hygiene prior to burial, cremation, or removal. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within t. of I has be Dept. certificate h h the State C this c CORECTOR: After 11 Nous after death v Item 28 is mark

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) Victrene M.Simpson 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 1 M 2 F 191-16-4550 9a. FACILITY NAME (If not institution, give street and nu 9b. CITY, TOWN OR LOCATION OF DEATH 17101 Clear Creek Silver Spring 10e STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Montgomery Silver Spring 10e. STREET AND NUMBER 101, ZIP CODE

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES

College (1-4 or 5 +)

(Son)

2. DATE OF DEATH 3. TIME OF DEATH 16, 1993 EAR March 2:00 PM . 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign July 4, 1911 Pennsylvania

9c. COUNTY OF DEATH

REG. NO

Montgomery 10d. INSIDE CITY 1 YES 2 NO

10g. CITIZEN OF WHAT COUNTRY? United States 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-if yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc.

1 TES 2 NO Specify Caucasian 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY

20905

Own Home 18. MOTHER'S NAME (First, Middle, Maiden Surname)

Flora Garman

19b. MAILING AODRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code)

3-20-93 Roslyn, Pennsylvania

59 Sutphin Pines Yardley, Pennsylvania 19067 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State

> 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home

( )ales () I can	11800 New Hampshire Ave.	Silver	Spring,	Md
33. PART I. Enter the diseases, or complicatione that ceused the death. shock, or heart fallure. List only one cause on each line.	Do not enter the mode of dving, such as cardiac or respiret	tory arrest,	Approxims interval Be	ta
IMMEDIATE CAUSE (Finel			Onset and	

Luna

HillSIDE CEMETERY

Homemaker

OUE TO (OR AS CONSEQUENCE OF)

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

PART II. Other eignificant conditions contributing to death but not reculting in the underlying cause given in Part I. 24e. WAS AN AUTOPSY PERFORMED?

246. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 YES 2 NO

YR

26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 Inpetient 2 ER/Outpetient 3 DOA me 5 Rasidence 6 Other (Specify) 4 Nursing Ho 28e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 28d. DEȘCRIBE HOW INJURY OCCUREO 1 YES 2 NO 26a. PLACE OF INJURY — At home, ferm, street, fectory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) end menner as stated.

2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(e) and men

29b. SIGNATURE AND TITLE OF CERTIFIER

30. NAME AND ADDRESS OF PERSON WHO COMPLE

HAGGERY 10

DHMH-16 Rev 1/89

YEAR

1988 Maryland

9c. COUNTY OF DEATH

Montgomery

10g. CITIZEN OF WHAT COUNTRY?

Specify

1993

U.S.A

N/A

2. DATE OF DEATH MONTH DAY

March 20,

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

Allison Joy Shaw

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VITAL RECORDS, P.O. BOA 60/60	and Shade
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4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. DAVE 1 M 2 F 216-27-0726 July 12, Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 18936 Tree Branch Terrace Germantown 10c. CITY, TOWN OR LOCATION Maryland Montgomery Germantown the funeral director, page 5 should be detached for use as the bunial-transit permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 18936 Tree Branch Terrace 20874 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Maxican, Puarto Rican, etc.) after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 1 Never Married 2 Married 1 TYES 2 XNO Specify: B 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION (Specify only highest grade complete COMPLETED 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during most of working life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 0 N/A once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 7 Mark C. Shaw Donna Payne BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 18936 Tree Branch Ter., Mark C. Shaw Germantown, MD 20874 must be 20s. METHOD OF DISPOSITION 20b. PLACE ANO OATE OF DISPOSITION (Name 20c. LOCATION -- City or Town, State DATE 1 X Burlai 2 Cremation 3 Removal from State
4 Donation 8 Other (Specify) Gate of Heaven Cemetery 3/23 Silver Spring, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY examiner De Vol Funeral Home 10 E. Deer Park Dr., Gaithersburg, medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory street, shock, or heart failure. List only one cause on each line. filled in by 6 IMMEDIATE CAUSE (FINAL RAIN Stem and completely fille burial, cremation, the state disease or condition resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): prior to if any, leading to immediate cause. Enter UNDERLYING physician CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events the attending p resulting in death) LAST 6 24a. WAS AN AUTOPSY PERFORMED? PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL signed by t Health and 23 shows any 1 - YES 2 T NO been . PHYSICIAN: Dept. 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Item State this certificate HOSPITAL: OTHER: tient 2 - ER/Outpatient 3 - DOA 1 TES 2 NO ng Home 5 X Residence 8 🗆 Other (Specify) 6 the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, with 1 X Natural 5 Pending 1 YES 2 NO BY After 2 Accident HOSPITAL OR ATTENDING 28a. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide .00 ETED 8 Could not be datarmined DIRECTOR: hours after hours after Item 28 4 Homicide COMPL 1 XCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, data and place, and due to the cause(s) and menner as stated. (Check only FLINEFAL WITHIN 72 I IMPORTANT: II AL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. A Sed 2 CAUSE OF DEATH (ITEM 27) (Type, Print)

MD 11) Michigan SPA 32. REGISTRADIS SIGNATURE
GILLA DAMAGORA AGORABLE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

09775

3. TIME OF DEATH

a.

3:55

10d, INSIDE CITY LIMITS? 1 YES 2 NO

14. RACE — American Indian, Black, White, atc.

White

MD 20877

Interval Between

Onget and Death

11 month

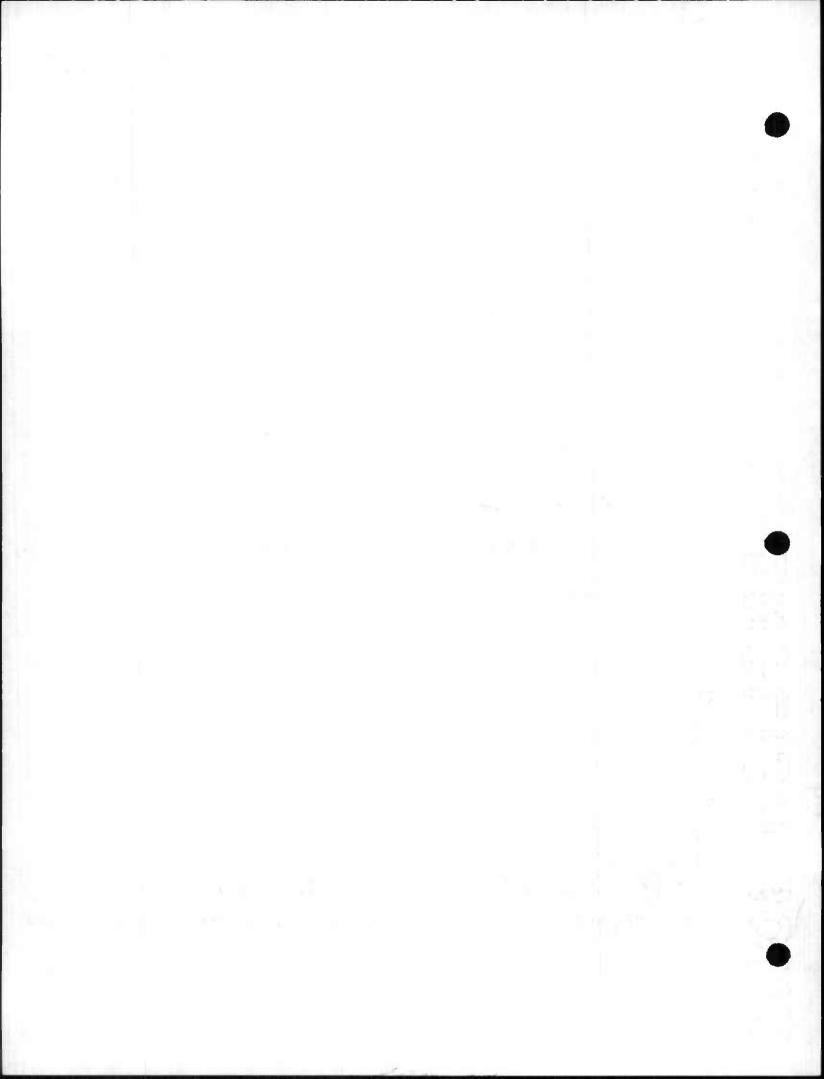
Approximate

24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO

DE DEATH? 1 | YE8 2 | NO

COMPLETION OF CAUSE

8. BIRTHPLACE (State or Foreign



Pages 1, 2, 3

permit.

ched for use as the burial-transit

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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#GSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the	FINERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be det.	within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	TANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notitled at one
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IMPORTANT: If

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93 09776 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN 1993 YEAR DAY HELEN В. THOMAS 21, March 6:58 AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. B. BIRTNPLACE (State or Foreign 056-05-3739 1 M 2 X F 92 YRS Feb. 2, 1901 Tennessee 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH DIRECTOR Bethesda Retirement and Nursing Cntr. Bethesda Montgomery RESIDENCE OF DECEDENT 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Washington, D.C. 1X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 3723 Morrison Street, NW 20015 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE - American Indian, 1 Never Married 2 Mar If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elamentary/Secondary (0-12) College (1-4 or 5+) 5 Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) Samuel Browder Elizabeth Patterson BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ Betsy Amin-Arsala 3723 Morrison St., NW Washington, D.C. 20015 20e. METHOD OF DISPOSITION
1 ☐ Buriel 2 N Cremetion 3 ☐ Rem 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE 4 Donation 5 Other (Specify) Comfort Crematory 3/23 Alexandria, VA 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY JOSEPH GAWLER'S SONS, INC. Mu 5130 WIsc. Ave., NW Washington, DC 20016 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, Approximata ahock, or haart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) Cerebral Infarction 3 days DUE TO (OR AS A CONSEQUENCE OF) Renal Failure, secondary 2 days MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If sny, leading to immediate cause. Enter UNDERLYING Hypertensive Vascular Disease months CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initisted events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO Atrial Fibrillation; Hyperthyroidism; Osteoarthritis; COMPLETION OF CAUSE 1 - YES 2 T NO Chronic Obstructive lung Disease. 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE DF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 - YES 2 X NO ma 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED MALKED, 1 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 26a. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) ED 8 Could not be 4 Nomicide determined E COMPL 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(a) end manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER

> 20815 5530 Wisconsin Ave., Chevy Chase, MD

DO 4686

29c. LICENSE NUMBER

32. REGISTRAR'S SIGNATURE Junia Davidson Andree

m

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

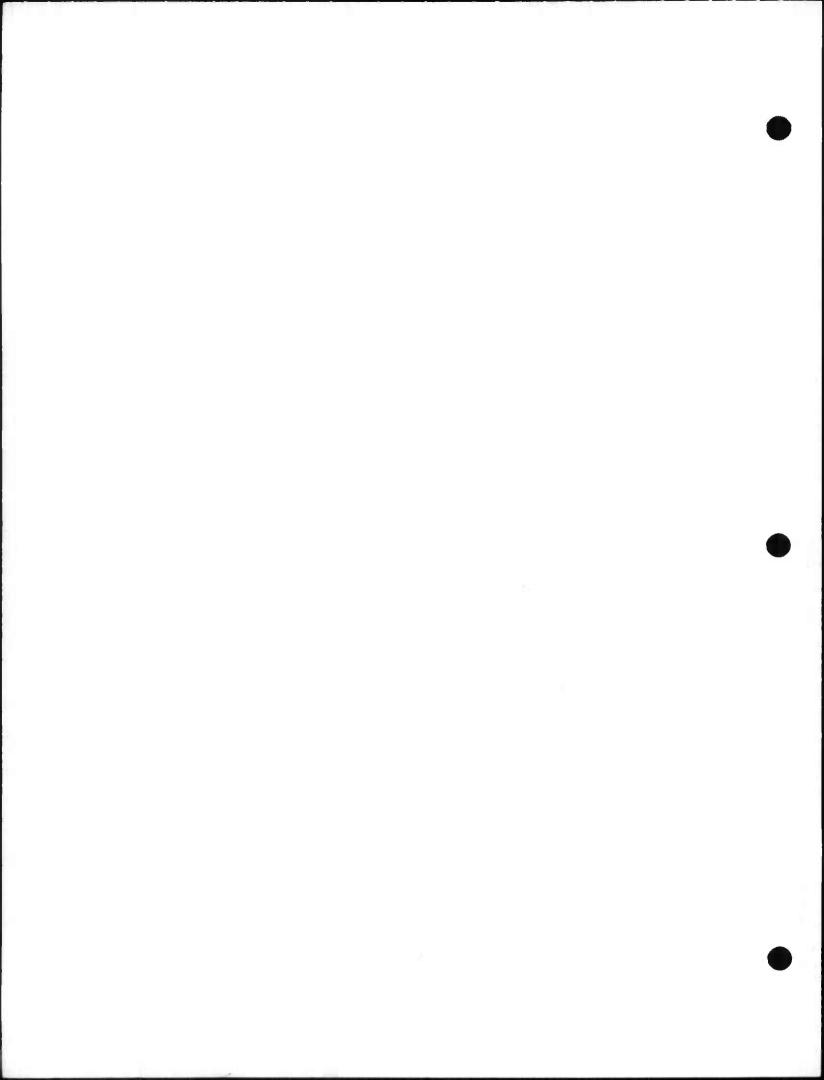
MD

Robert F. Dyer,

31. DATE FILED (Month, L

29d. DATE SIGNED (Month, Day, Year)

March 22, 1993



DIVISION OF VITAL RECORDS, P.O. BOX 68760, HOSPITAL OF ATTENDING PHYSICIAN:

31. DATE FILED (Month, Day, Year)

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32. REGISTRAR'S SIGNATURE

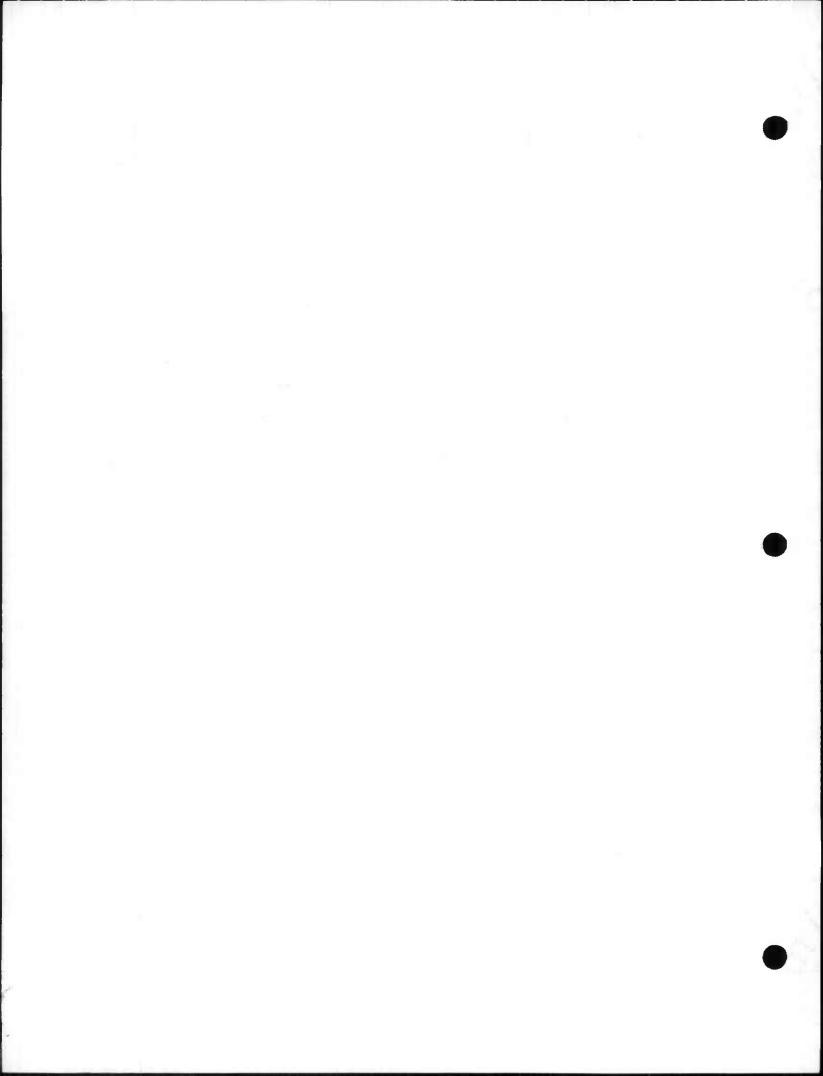
Lulia Davidson

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The law rec	tie has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit p	Dept.	om 23 shows any injury, or other traumatic event, the medical examiner must be notified at once
ne	ite h	are	E

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 12:40 Q YEAR 4. SOCIAL SECURITY NUMBER CONNIE Lomas -32-OM 7. DATE OF BIRTH (Month, Day, Year)
July 9, 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 578-52-0160 1 M 2 X F 62 1931 Pennsylvania Sa. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Holy Cross Hospital DIRECTOR Silver Spring Montgomery RESIDENCE OF DECEDENT 10a. STATE 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. Montgomery Silver Spring 1 XYES 2 NO FUNERAL 10e. STREET AND NUMBER 10/ 7ID CODE 10g. CITIZEN OF WHAT COUNTRY? 507 Kerwin Court 20901 U. S. A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 XYES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, 1 Never Married 2 Married 1 YES 2 NO Specify: ВҰ 3 Widowed 4 Divorced Korean Black COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) 12 Budget Officer Federal Government 17. FATHER'S NAME (First, Middle, Last)
Mack T. Thomas 16. MOTHER'S NAME (First, Middle, Maiden Surname)
Nellie Slaughter BE 19a. INFORMANT'S NAME (Type/Print)
Theresa Hawkins 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 507 Kerwin Court, Silver Spring, Md. 20901 9 20s. METHOD OF DISPOSITION
1 Burlel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Brair Memorial Park Altoona, Pa. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. N. Horton Co. Morticians, Inc. 600 Kennedy Street, N. W. 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fellure. List only one cause on each line Interval Between Onset and Death **IMMEDIATE CAUSE (Final** disease or condition \_\_\_\_ 112 Cand DUE TO (OR AS A CONSEQUENCE OF): hung Cardial De Sease Cardio MEDICAL CERTIFICATION Sequentielly list conditions, DUE TO (DR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 | YES 2 | NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL:
1 | Inpatient 2 | ER/Outpetient 3 | DOA this certificate with the State irked, or Iter OTHER: ne 5 - Residence 6 - Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 28 is marked, 1 Natural 5 Pending Investigation 1 YES 2 NO BY FLUERAL DIRECTOR: After Infilin 72 hours after death 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 29s. CERTIFIER (Check only one)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 MAFDICAL FYAMINER: On the hasis of examination and/or investigation. In my coinion, death occurred at the time, data and place, and due to the course. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER BE ( 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, 7800 -20-6 46 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) auber 8-278-WISCONSW ADR Feettun as



BALTIMORE, MARYLAND after death. Page 6 may be retained by the hosp by the funeral director, page 5 should be detached	noval. cal examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,  TO THE HOSPING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp TO THE FUNE W. The certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior burial, cremation, or removal.  IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
DEVISION OF VITAL RE( THE HOSPING OF ATTENDING PHYSICIAN: The law requir	iled within 72 hours after death with the State Dept. of H PORTANT: If Item 28 is marked, or Item 23 show
7	2 %

	1 - STATE REGISTRAR	STATE OF MARYLAND /	DEPARTME	NT OF HEALTH	AND ME	NTAL HYGIENI REG. NO.	E	05110
	1. DECEDENT'S NAME (First, Middle, Last) HATTU	Talbot			2.	DATE OF DEATH DA	Y - 93	3. TIME OF DEATH 4:58 A M
		1½ M 2 □ F 89	EX 6. AGE (In yrs. last birthday)   F UNDER 1 YEAR   F UNDER 24 HHS.   7. DATE OF BIRTH (Month, Day, Year)   SEPT, 11, 1903					
TOR	SUBURBAN HOSPI RESIDENCE OF DECEDENT		96. CI	BETHESD		4	9c. COUNTY OF	IGOMERY
DIRECTOR	10a. STATE 10b. COUNTY	OMERY	10c. CITY, TOWN	OCKVILLE				10d. fNSIDE CITY LIMITS? 1 X YES 2 NO
FUNERAL	10e. STREET AND NUMBER	RD. #1022	1 410	10f. ZIP CODE	0852			F WHAT COUNTRY?
BY		12. WAS DECEDENT EVER IN U.S. AR FORCES? 1 TYES 2 THE IF YES, GIVE WAR OR DATES	RMED 1	3. WAS DECENDENT OF IT YES 2 NO	F HISPANIC (		or No- 14. RA	OCE — American Indian, ack, White, etc.
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade co	impleted) (G	. Do NOT use retired	ne during most of working	g	16b. KIND OF BUS	INESS/INDUSTRY	
OMP	17. FATHER'S NAME (First, Middle, Last)	_2	C.P.A.	18. MOTH	IER'S NAME	(First, Middle, Maiden 3	CCOUNTI	ING
BE C	BENJAMIN	TABACHNICK			UNK		ILVERM	M
2	19a. INFORMANT'S NAME (Type/Print)	19	_	SS (Street and Number				
Ė	BERNARD TALBOT  200. METHOD OF DISPOSITION	20b, PLACE	AND DATE OF DISP	OREST RD.	BET		CATION — City or	
	1 Donation 5 Other (Specify)	CHA	AMBERS C	REMATORY	3/		RIVERDAL	
	21. SIGNATURE OF FUNERAL SERVICE LICE	emberse Mod	0091 W	2. NAME AND ADDRES	BERS (	CO. INC.	SILVER	20910 SPRING,MD.
z	IMMEDIATE CAUSE (Final disease or condition resulting in death)	mplications that caused the dest only one cause on each line  RESPIR  Ly foire the  DUE TO (OR AS A CONSE	ATORY	FAILURE		s cardiác or respli	ratory arrest,	Approximate interval Between Oneet and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSECUTION OF TO (DR AS A CONSE	QUENCE OF):					
MEDICAL	CORONARY HEART	- dijear	resulting in the	underlying ceuse g	iven in Par	t I. 24a. WAS AN PERFORI	MED?	4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	ОТН	26. PLACE OF DE	EATH (Check	only one)		
HYS	1 VES 2 ND 1	28e. DATE OF INJURY	28b. TIME OF	28c. INJURY AT		Other (Specify)	JURY OCCURED	
ВУ Р	Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY M	WORK?				
	3 Suicide 6 Could not be 4 Homicide determined	28e, PLACE OF INJURY — At he building, etc. (Specify)	ome, farm, street, f	actory, office	26	if. LOCATION (Street e City or Town, State)	nd Number or Run	al Route Number,
COMPLETED		AN: To the best of my knowledge, de Dn the baels of examination end/or						e(s) and menner ee stated.
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	21.1	1 -	29c. LICE	NSE NUMBE	R C 7	29d. DATE SIGN	ED (Month, Day, Year)
70	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH (ITE	M 27) (Type, Print)		( )	0/	0 / 1/	15-13
	31. DATE FILED (Month, Day, Ybar) MAR 22 93	32. JEGISTRARIS SIGNATURE	hondell.	Congres	J 10 hc	of Lhae, 6	Richvill.	yno wis

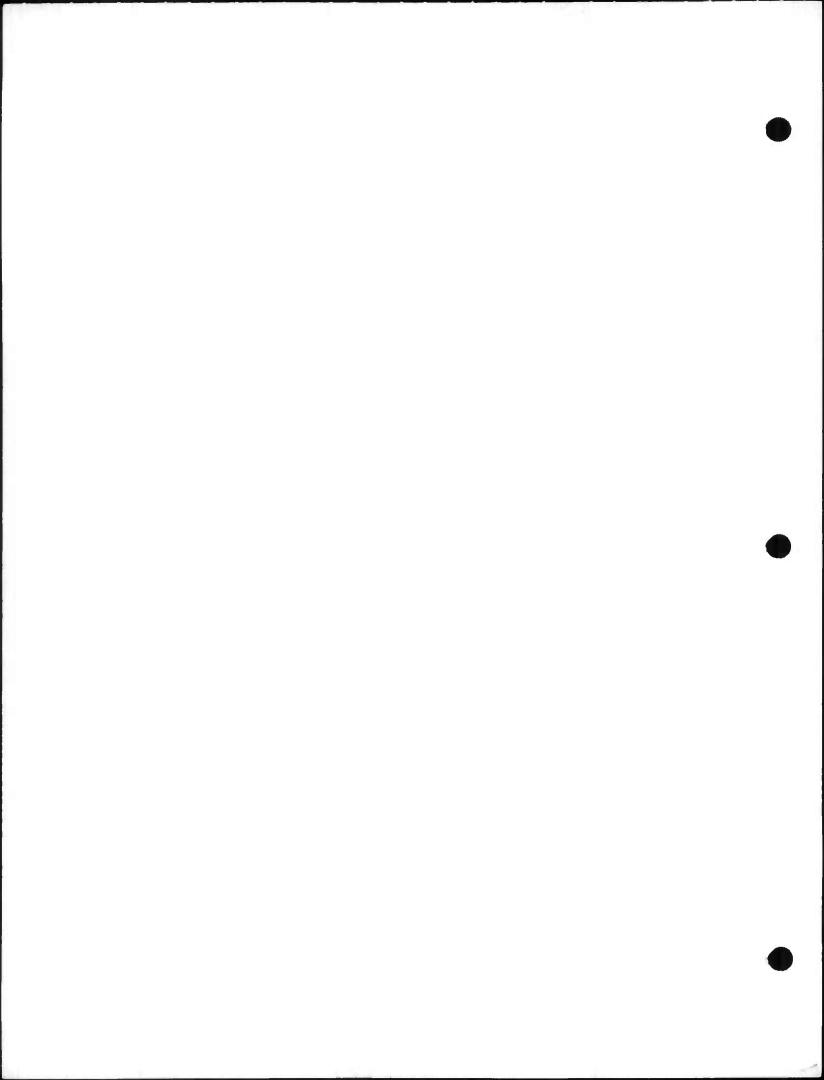
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ITEMS: 23 PART I, 27,28e,f , PER MEO G-698 4/8/93 t.t 93 09779

	1 - STATE REGISTRAR	STATE OF MARYLAN	D / DEPAR	TMENT OF H	HEALTH AND		GIENE G. NO.		•	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DE	EATH		ME OF DEAT	тн
	STEPHANIE  4. SOCIAL SECURITY NUMBER	LYNNE			TERS	03			14	P
	214-82-7562	104006	rs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIF (Month, Day,	Year)	Country)		oreign
	9e. FACILITY NAME (If not institution, give st	A 23		9b. CITY, TOWN (	OR LOCATION OF DE	SEPT. 16		IRGIN:	[A	
CTOR	11,812 PINE TRE	CE COURT		MONROV				ERICK	5	
DIRE	MARYLAND FRED	ERICK		y, town or locat ONROVIA	TION				INSIDE CITY LIMITS? YES 2	
IERAL	100. STREET AND NUMBER  11812 PINE TREE CO	OURT		101	21770			N OF WHAT	COUNTRY?	
BY FUNI	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S FORCES? 1 _ YES 2 IF YES, GIVE WAR OR DATES	V NO	If yes, sp	CENDENT OF HISPAN Hecity Cuben, Mexica 3 2 NO Specify	n, Puerto Rican,	cify Yes or No- 14	4. RACE — Ar Black, Whit Specify: WHTTF	te, etc.	ien,
PLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	Give kind of a life. Do NOT us  HOMEMA		ON ost of working	16b. KIND	OF BUSINESS/INDUS		-	
COMP	17. FATHER'S NAME (First, Middle, Last)		помема	KEK	16. MOTHER'S NA	ME (First, Middle,	Maiden Surname)			
BE C	CARL BRUCE HOGAN	<u> </u>			LINDA	ANN BOO	SASH			
0	19e. INFORMANT'S NAME (Type/Print)					Route Number, City	y or Town, State, Zip C	ode)		
	JOHN J. G. WATERS	(HUSBAND)		PINE TRE			IA, MARYL		21770	
	20e_METHOD OF DISPOSITION    A Buriel   2   Cremation   3   Remo	ovel from State cemeter GAT	y crematory or of E OF H		METERY		SILVER SP			AND
	21. SIGNATURE OF FUNERAL SERVICE LIC			FRANCI	S J. COL	CILITY LINS FU	NERAL HOI	ME, IN	VC.	
	iMMEDIATE CAUSE (Fine)	omplications that ceused th List only one cause on eech b. INTRA-ORAL CO DUE TO (OR AS A CO	ONTACT	GUNSHOT		h aa cerdiac o	r reapliratory arrea	1	Approxim interval B Onset and	etween
RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CO	Ly .		7					
1 141 1	resulting in death) LAST	i								
MEDICAL	PART II. Other significant conditions	a contributing to deeth but r	not resulting i	n the underlying	g ceuse given in		AAS AN AUTOPSY PERFORMED? YES 2   NO	AMAIL COMP OF DI	AUTOPSY FI ABLE PRIOR PLETION OF C EATH? YES 2 1	TO CAUSE
SICIAN:	25. WAS CASE REFERRED TO MEDICAL		<del></del>	26. PL	ACE OF DEATH (Che	eck only one)		1		
YSIC	EXAMINER?	HOSPITAL: 1 ☐ Inpetient 2 ☐ ER/Outpetie	nt 3 🗆 DOA	OTHER: 4   Nursing Hom	e 5) Assidence	6 Other (Spec	ffy)			
РНҮ	27. MANNER OF DEATH  1 Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIMI	E OF 28c. INJ URY WO	RK?	28d. DESCRIBE	HOW INJURY OCCU	RED		
ВУ	2 Accident Investigation	3-19-1993 286. PLACE OF INJURY - /			YES 2 NO		CT SHOT			
TED	8 Could not be 4 Homicide determined	building, etc. (Specify)	AT HO			City or Town	PINE :	v j a l	Md COUR	γт
COMPLET		CIAN: To the best of my knowledge.	e, death occurre	ed at the time, date		to the cause(s) s	and menner as stated.			
	SIGNATURE AND TIPLE OF CENTIFIER			1	29c. LICENSE NUM			SIGNED (Monti		asied.
TO BE	30. NAME AND ADDRESS OF PERSON WHO	ll And	(ITEM 27) /5cm	Print1	O.C.M.			20-19		
	MARIO F. COLLE J	1/			et, Bal	Ltimor	e, Mary	land	212	01
	31. DATE FILED (Month, Day, Year) MAR 3 102	32. REGISTRAR'S SIGNATUR								

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m	E ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after d	
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	5	-
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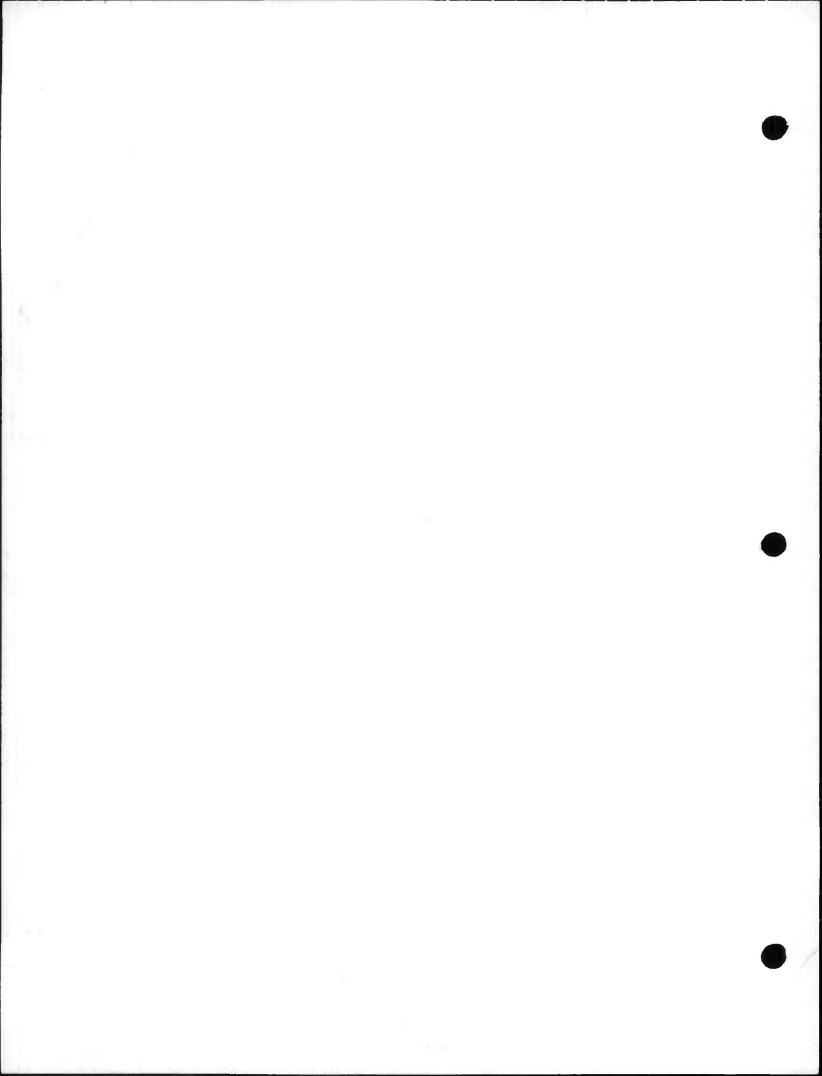
		1 - STATE REGISTRAR	1	STATE OF MA	RYLAND /	DEPART	MENT OF H	EALTH AND	MENTA	L HYGIEN				
		1. DECEDENT'S NAME (First, A	Aiddle, Last)						2, DATE	OF DEATH			. TIME OF DEATH	
		DONALD	C.		WALTO					CH 20,	1993	YEAR	8:00 P	М
		4. SOCIAL SECURITY NUMBER		SEX 6.	AGE (In yrs. le:		IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	(Mon	OF BIRTH th, Day, Year)		B. BIRTHPI Country)	ACE (State or Forei	gn
pinous		011-07-5834  9a. FACILITY NAME (If not insti		**	90		9h CITY TOWN (	OR LOCATION OF I		.27,19		MAIN		
1, 2, 3 sh	DIRECTOR	HOLY CROS	S HOSE	PITAL	<u></u> -			ER SPRI		_	9c. COUNT	TGOM		
	REC		10b. COUNTY	<del></del>		10c. CITY,	TOWN OR LOCAT	TION				1	Od. INSIDE CITY	
020 physician. burial-transit permit. Pages	AL DI	MARYLAND  100. STREET AND NUMBER	MON'	TGOMERY		1	ROCKVIL	LE ZIP CODE					LIMITS?  YES 2 NO	5
nsit p	ER/	4901 JASMINE	EDRIVE				100	20853			lug. Ci lizi			
020 physician. burial-tran	FUNER	11. MARITAL STATUS	12	. WAS DECEDENT EX	ER IN U.S. AF	MED	13. WAS DEC	ENDENT OF HISPA	ANIC ORIGI	N? (Specify Yea	or No— 1	USA 4. RACE -	- American Indian, Whita, atc.	_
21215-0020 If or attending physic for use as the burial	B≺	1 Never Married 2 M 3 Widowed 4 Divorce		FORCES? 1   IF YES, GIVE WAR		NO		ecify Cuban, Mexic 200 NO Spec		Rican, etc.)		Specify:	White, etc.	
2121 al or atter for use a	ETED	15. DECED (Specify only h	DENT'S EDUCATION IN THE PROPERTY OF THE PROPER	ON (pleted)	(G	iive kind of wo	SUAL OCCUPATION NO MAIN NO MANDATO MANO MANDA NO MAIN NO MAIN NO MAIN NO MAIN NO MAIN NO MAIN NO MAIN NO MAIN NO MAIN	ON est of working	161	. KIND OF BUS	SINESS/INDU			
	7	Elementary/Secondary (0-12	2) C	ollege (1-4 or 5+)	1176	. Do NOI use	retired.)							
AND 2 the hospital detached fo	COMPLE	17. FATHER'S NAME (First, Midd	de, Lest)	4	ISUP	ERVISO	)R	16. MOTHER'S N				BELL.	TELEPHO	NF.
# 8 € ₹	BE C	HERBERT	WALTON					AGNE		CAMERO	0.00			
MARN retained to 5 should in	TO B	19a. INFORMANT'S NAME (Type			19	b. MAILING A	DDRESS (Street a	nd Number or Rura				Code)		
≥ 00 E	-	DONALD C. WA		IR. (S	ON) 4	901 J	SMINE I	ORTVE R	OCKV.	ILLE, MA	ARYLAN	ID 20	853	
ORE, I e 6 may be ector, page a		20a. METHOD OF DISPOSITION	3 Removal		20b. PLACE : cemetary, cre	AND DATE OF	DISPOSITION (Na or place)	me of	DAT		CATION — CI			
Page direc		4 ☐ Donation 6 ☐ Other (S		EE/	MT. P	LEASAN	T CEMET	CERY ID ADDRESS OF F	ACH ITY	ROCK	CLAND,	MASS	ACHUSET'	rs_
ALTIMORE, death. Page 6 may be e funeral director, page L. examiner must be		> MO.K	15 1	K		SR.	FRANCI	IS J. CO	LLINS					
B after by the moval		23. PART I. Enter the dise	esses, Dr com	plications that ce	used the de	ath. Do no	1500 UN	VIVERSIT	Y BLV	/D.,W.	SIL.S	PR.,	MD.2090	
		ahock, or hea IMMEDIATE CAUSE (Final	in leliure. Liat	only one ceuse	on each line	l,		ao on aying, sa	on an car	unac or reapn	atory arres	at,	Approximate interval Bets Onset and D	reen
		disease or condition resulting in death)		mesonrous 740					an a	1515			Onest and D	watti
≥ 5 5 ± 5		•		DUE TO (OR AS A CONSEQUENCE OF):										
and and bur	CERTIFICATION	Sequentially list conditions,  Due TO (OR AS A CONSCOUENCE OF):												
BOX ficate be as physician a ne prior to	CAT	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury										j		
. 4 9 6 2	F	that initiated events resulting in death) LAST		DUE TO (OR	AS A CONSE	DUENCE OF):								
0. 6 5 0	CER		d										-	
E SE E	Ä	PART II. Other algoliticant	conditiona co	ntributing to death but not recuiting in the undarlying cause given in					PERFORMED? AVAILA			ERE AUTOPSY FIND	NGS	
RECORD requires that the peen signed by to of Health and shows any in	EDIC/								1 TYES 2	NO NO	0	OMPLETION OF CAU F DEATH?	SE	
~ 2 2 5 A	2									,		1	YES 2 NO	
AL F he law e has be e Dept. m 23 s	SICIAN:	25. WAS CASE REFERRED TO B	MEDICAL				26. PL	ACE OF DEATH (C	heck only or	10)				
F VITA SICIAN: The certificate h the State [	YSIC	EXAMINER?	18	SPITAL: Inpatient 2 - ER	Outpatient 3		OTHER:	5 🗆 Rasidence	6 🗆 Othe	r (Specify)				
OF PHYSIC this cer with th	PHY	27. MANNER OF DEATH  1 Netural 5 Per	ndina	26a. DATE OF INJU (Month, Day, Y		26b. TIME		URY AT RK?	28d. DE	CRIBE HOW IN	JURY OCCU	RED		
ON O DING PHYS After this death with	B	2 Accident Inv	estigation	26. DI ACE OF IN	HIDY As be	45		ES 2 NO						
VISI ATTEN ECTOR: s after 1 28 i	ETED		uld not be termined	26a. PLACE OF IN- building, atc.	(Specify)	me, rarm, str	eet, factory, office		261. LOC City	ATION (Street as or Town, State)	nd Number or	Rural Rou	te Number,	
DI NE CIR	MPL			: To the best of my										
18	3			n the basis of exemi	nation and/or i	nveatigation,	In my opinion, de	eath occured at the	e firme, data	and placa, and	f due to the	cause(a) a	nd manner aa state	id.
E E W	0 86	29b. SIGNATURE AND TITLE OF	2/	lle				29c. LICENSE NU	MBER 562	5	29d. DATE 5	2 2	onth, Day, Year)	
10		30. NAME AND ADDRESS OF P	T. /	Boy /e	F DEATH (ITE			DCTA ATT	entre #	201 07	TUES	ODD T	10 vm	
		31. DATE FILED (Month, Day, You		00 05010704010	SIGNATURE		313 GEO	RGIA AVI	ENUE#	201 SI	LVER	SPRI	NG.MD.	_
		MAR 23 '93		Julia David	Josh- / Cary	علاك								



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CIAN: The law requires that the death certificant be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	becilicate has been signed by the attending physician and completely filled in by the larger direction, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Debt, of Health and Mental Hydiem prior to the human depth of Health and Mental Hydiem prior to the human depth of Health and Mental Hydiem prior to the human depth of Hydiem prior to the human depth of Hydiem prior to the human depth of Hydiem prior to the hydiem prior to the human depth of Hydiem depth of Hyd	the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certifican be executed within	TO THE PUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complexity filled in by the be flied within 72 hours after death with the State Deot, of Health and Mental Hydiem puter to burn, ceremation, or minorest	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examines must be notified at once.

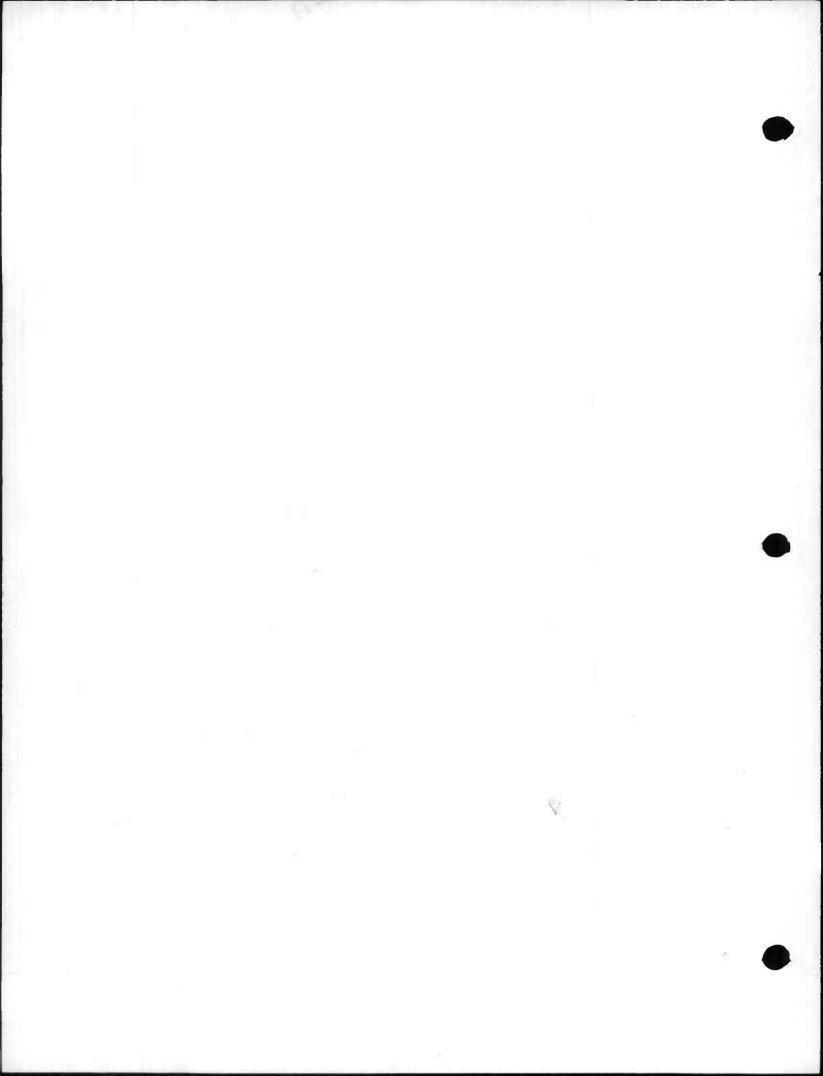
	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFICA			MENTAL HYGIEN	4	3 09781
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	Thelma	S.	WALKER				8 199	3 12:05A M
			In yrs. lest birthday) IF I	MOER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIFTH (Month, Day, Year)	8.	BIRTHPLACE (State or Foreign Country)
	211 20 0137	1 M 2 F 8	4 YRS.	THO DATE	mounts mm,			ORTH CAROLINA
· ·	9a. FACILITY NAME (If not institution, give stre		9b.	CITY, TOWN O	R LOCATION OF DE	ATH	9c. COUNTY	
DIRECTOR	DOCTORS HOSPITA	<u>L</u>		LANHAM	[		PRINC	CE GEORGES
REC	10a. STATE 10b. COUNTY		10c. CITY, TO	WN OR LOCAT	ION			10d. INSIDE CITY
	MARYLAND PRIN	CE GEORGES	UPPE	R MARL	BORO			1 YES 2 NO
FUNERAL	10e. STREET AND NUMBER			101.	ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
岁		DLLOW LANE			2077		USA	
5	11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO			IC ORIGIN? (Specify Yen, Puerto Rican, etc.)	s or No- 14.	RACE — American Indian, Black, White, etc.
B	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE WAR OR DA	TES**	1 TYES	2 NO Specify	*		Specify:
G	15. DECEDENT'S EDUCA (Specify only highest grade or		16a. DECEDENT'S USU	AL OCCUPATIO	N .	16b. KIND OF BU	SINESS/INDUST	WHITE
E	Elementary/Secondary (0-12)	College (1-4 or 5 +)	(Give kind of work in ite. Do NOT use ret	red.)	st or working			
COMPL	12		BANKING C	LERK		BANKIN	G	
8	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAI	WE (First, Middle, Maiden	Sumame)	
8	EDWARD  19a. INFORMANT'S NAME (Type/Print)	STRICKLAND	100 HAH INC 100	meno (Charles	MARY	P loute Number, City or Tov	ATE	
일	JAMES F. WALKER		1					
1 1	20a, METHOD OF DISPOSITION	20b	PLACE AND DATE OF DE	SPOSITION (Na	me of		AKLBURU CATION — City	or Town, State
	1 Donation 5 ☐ Other (Specify)	ral from State	ROSPECT HI	LL CEM	ETERY	3/22 WAS	HINGTON	I. DC
П	21. SIGNATURE OF FUNERAL SERVICE LICES			22. NAME AN	D ADDRESS OF FAC	YTI IE		
	Limothy	H. Campl	rell	500 UN	IVERSITY	BLVD., W	., SIL.	ME, INC. SP., MD 20901
П	23. PART I. Enter the diseases, of co shock, or heart failure. Li	mplications that caused	the death. Do not e	nter the mod	de of dying, suct	as cardiac or resp	iratory arrest.	Approximate
	IMMEDIATE CAUSE (Final		2010 19224					Interval Between Onset and Death
	disease or condition	SEPTIC DUE TO (OR AS A	EMIA					
				7	Ť	C .		
No.	Sequentially list conditions, b.	A Certe Re	CONSEQUENCE OF	y D.	12/2022	dynds	con	
F	if any, leading to immediate cause. Enter UNDERLYING	Diabe	1					İ
F	CAUSE (Disease or injury that initiated events		CONSEQUENCE OF):					
CERTIFICATION	resulting in death) LAST d.	Pylon	estintes	•				
7	PART II. Other significant conditions	contributing to death b	ut not resulting in th	e underlying	cause given in I	Part I. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS
2		Decembite				PERFO		AMAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC								OF DEATH?
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			ACE OF DEATH (Che	ck only one)		
YSI	1   YES 2   NO	1 Inpatient 2 ER/Outp	atient 3 DOA 4 D	HER: Nursing Home	5 🗆 Residence	6 Other (Specify)		
	27. MANNER OF DEATH  1 Natural 5 Pending	(Month, Day, Year)	28b. TIME OF INJURY	28c. INJU	RK?	28d. DEŞCRIBE HOW	INJURY OCCURI	ED
В	2 Accident Investigation	260 PLACE OF IN HIPY	At home, farm, street		ES 2 NO	244 1 2 2 4 7 2 7 7 7		
	3 Suicide 6 Could not be 4 Homicide determined	building, atc. (Spec	ify)	, ractory, ornea		261. LOCATION (Street City or Town, State,	and Number or F	tural Houte Number,
	29a. CERTIFIER 1 TO CERTIFYING BUYERS	AN: To the heat of an invest			37.0			
COMPLETED		AN: To the best of my knowl						ruse(s) and menner as stated.
	29b. SIGNATURE AND TITUS OF CERTIFIER				29c, LICENSE NUM		1	GNED (Month, Day, Year)
BE (	Lex	yayen	/		20155	58	▶ 3	119/92
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Print	)			7	- / ( • )
	S.C. ARYANGAT	-,MD, 330	18 PERR	y Sz.	MT.	RAINIE	R, MI	0 20712
	31. DATE FILED (Month, Day, Year) MAR 23 'Q2	32. REGISTRAR'S SIGN	Panda P2					



BALTIMORE, MARYLAND 21215-0020	rSICIAN: The law requires that the death certificate be executed within 2* hours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the tuneral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	on, or removal.	ne medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOS THE CENTER OF PHYSICIAN: The law requires that the death certificate be executed within 2	TO THE FUNDAM CIPECION And this certificate has been signed by the attending physician and completely to	be filed with the state of the state Dept. of Health and Mental Hygiene prior to bunal, crematic	IMPORTANT The marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND	MENTAL HYGIENE
CERTIFICATE OF DEATH	REG. NO.
	2. DATE OF DEATH

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTME CERTIFICA	NT OF HEALTH AND TE OF DEATH	MENTAL HYGIENE REG. NO.		77102
1	1. DECEDENT'S NAME (First, Middle, Last	)		_	2. DATE OF DEATH		3. TIME OF DEATH
	RICH	ARD JOHN WICK	LUND		MAR 16	1993 YEAR	12:51 A M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (	(In yrs. lest birthday) IF UN	DER 1 YEAR   IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTH Count	IPLACE (State or Foreign
	563-36-0807	¹√ M 2 □ F 59	YRS.	TO DAYS HOURS MIN.	APR 16 19		FORNIA
-	Se. FACILITY NAME (If not institution, give	street and number)	9b. C	TTY, TOWN OR LOCATION OF E	HTABO	9c, COUNTY OF D	EATH
5	NATIONAL NAVAL	MEDICAL CENTE	ER	BETHESDA		MONTGO	OMERY
EC	10e. STATE 10b. COUN	TY	10c, CITY, TOW	IN OR LOCATION			10d. INSIDE CITY
DIRECTOR	VIRGINIA	FAIRFAX		ANNANDALE		1	LIMITS?
	10s. STREET AND NUMBER			101. ZIP CODE		10g. CITIZEN OF V	
FUNERAL	4127 MASON RIDG	E DRIVE		2200	)3	UNITE	ED STATES
5	11. MARITAL STATUS	12. WAS DECEDENT EVER IF	N U.S. ARMED	13. WAS DECENDENT OF HISPA	ANIC ORIGIN? (Specify Yes o	r No- 14. RACI	- American Indian.
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 X YES		If yes, specify Cuban, Mexic 1 TYES 2 NO Spec		Speci	c, White, etc.
		1957 - 198					WHITE
COMPLETED	15. DECEDENT'S ED (Specify only highest grad	de completed)	16a. DECEDENT'S USUAI (Give kind of work do life. Do NOT use retire	ne during most of working	166. KIND OF BUSIN	NESS/INDUSTRY	
12	Elementary/Secondary (0-12)	College (1-4 or 5+)					
OM	17. FATHER'S NAME (First, Middle, Last)		U.S.		DEFENSE AME (First, Middle, Meiden St	mamal	
U U	VERNER JOHN WI	CKLIIND			FRANCES MO	,	7
00	19a. INFORMANT'S NAME (Type/Print)	OKECKD	196. MAILING ADDR	ESS (Street and Number or Rura			
유	DORALYN WICK	LUND		SON RIDGE DRI	-		2003
	20a. METHOD OF DISPOSITION 1 A Burial 2 Cremation 3 Re	206	PLACE AND DATE OF DISP	POSITION (Name of		ITION — City or To	
	4 Donation 5 Other (Specify)	Same State	netery, crematory or other pla inta Rosa Me	emorial Park	3/23 Santa	a Rosa,	California
	21. SIGNATURE OF FUNERAL SERVICE L	JCENSEE	211	22. NAME AND ADDRESS OF F DEMAINE FUNE	ACILITY DAT HOMES	TNC	
	1 Danhe	el a) o'	John !	ALEXANDRIA,		INC	
	29. PART I. Enter the diseases, or	complications that cause	the death. Do not en			tory arrest.	Approximate
	shock, or heart fellure IMMEDIATE CAUSE (Finel	. List only one cause on e	ach line.		AND SHOP STORES		Interval Between Onset and Death
	disease or condition resulting in death)		CARDIOP	ULMONARY ARRE	EST		
	resoning in death)	DUE TO (OR AS A	CONSEQUENCE OF):	OLITOTALICE THEIR	301		
Sequentially list conditions, HEMORRHAGE FROM ABBERANT AORTIC BRANCH							
Ĕ	if any, leading to immediate cause. Enter UNDERLYING		CONSEQUENCE OF):	CTOMY			
일	CAUSE (Disease or Injury	с	CONSEQUENCE OF);	CIONI			
CERTIFICATION	that initiated events resulting in death) LAST						
B		d					
4	PART II. Other algnificent condition	ns contributing to deeth b	ut not resulting in the	underlying cause given is	Part I. 24s. WAS AN AI		WERE AUTOPSY FINDINGS MAILABLE PRIOR TO
la la					1 X YES 2	NO E	COMPLETION OF CAUSE OF DEATH?
					_		1 - YES 2 NO
≥							
AN: M							
ICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER? CLEARED BY			26. PLACE OF DEATH (C			
HYSICIAN: M		1 to Inpatient 2 - ER/Outp	etient 3 DOA 4 1	IER: Nursing Home 6 - Residence	6 Other (Specify)		
PHYSICIAN: MEDIC	EXAMINER? CLEARED BY 1 YES 2 NO  27. MANNER OF DEATH  1 Notural 5 Pending	1 Inpatient 2 ER/Outp 28a. DATE OF INJURY (Month, Day, Year)		IER: Nursing Home 6 Residence 28c, INJURY AT WORK?		URY OCCURED	
à	EXAMINER? CLEARED BY 1 VES 24 NO  27. MANNER OF DEATH  1XXNatural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Dey, Year)  28a. PLACE OF INJURY 28a. PLACE OF INJURY	28b. TIME OF INJURY M	IER: Nursing Home 6 Residence 28c. INJURY AT WORK? 1 YES 2 NO	6 Other (Specify) 28d. DESCRIBE HOW INJ		Route Number
ED BY	EXAMINER? CLEARED BY 1 YES 2 NO M E  27. MANNER OF DEATH 1 X Netural 5 Pending	25a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	IER: Nursing Home 6 Residence 28c. INJURY AT WORK? 1 YES 2 NO	6 Other (Specify)		lloute Number,
ED BY	EXAMINER? CLEARED BY  1 YES 2 NO  27. MANNER OF DEATH  1 X Netural 5 Pending Investigation 3 Suicide 6 Could not be determined	28e. PLACE OF INJURY 28e. PLACE OF INJURY building, etc. (Spec	29b. TIME OF INJURY M	IER: Nursing Home 6 Residence 28c. INJURY AT WORK? 1 YES 2 NO factory, office	6 Other (Specify)  28d. DESCRIBE HOW INJ  28f. LOCATION (Street and City or Town, State)	d Number or Rural F	Route Number,
ED BY	EXAMINER? CLEARED BY  1 YES 2 NO  27. MANNER OF DEATH  1 X Netural 2 Accident 3 Suicide 6 Could not be determined  29a. CERTIFIER (Check only)	28a. DATE OF INJURY (Month, Day, Year)  28a. PLACE OF INJURY building, etc. (Spec	29b. TIME OF INJURY M  — At home, farm, street, 1/1/2/1	IER: Nursing Home 6 Residence 28c. INJURY AT WORK? 1 YES 2 NO factory, office	6 Other (Specify)  28d. DESCRIBE HOW INJ  28f. LOCATION (Street and City or Town, State)  e to the cause(a) and manner	d Number or Rural F	
COMPLETED BY	EXAMINER? CLEARED BY  1 YES 2 NO  27. MANNER OF DEATH  1 X Netural 2 Accident 3 Suicide 6 Could not be determined  29a. CERTIFIER (Check only)	28a. DATE OF INJURY (Month, Day, Year)  28a. PLACE OF INJURY building, etc. (Special Strains)  SICIAN: To the best of my know  NER: On the bests of examination	29b. TIME OF INJURY M  — At home, farm, street, 1/1/2/1	IER: Nursing Home 6 Residence 28c. INJURY AT WORK? 1 YES 2 NO factory, office  ne time, data and place, and du ny opinion, death occured at th	6 Other (Specify)  28d. DESCRIBE HOW INJ  28f. LOCATION (Street and City or Town, State)  e to the cause(e) and manner time, data and place, and	d Number or Rural F ar as stated. due to the cause(a	) and manner as stated.
BE COMPLETED BY	EXAMINER? CLEARED BY  1 YES 2/ NO  27. MANNER OF DEATH  1 X Netural 5 Pending Investigation 3 Suicide 6 Could not be determined  29e. CERTIFIER (Check only one)  2 MEDICAL EXAMIN	28a. DATE OF INJURY (Month, Day, Year)  28a. PLACE OF INJURY building, etc. (Special Strains)  SICIAN: To the best of my know  NER: On the bests of examination	29b. TIME OF INJURY M  — At home, farm, street, 1/1/2/1	IER: Nursing Home 6 Residence 28c. INJURY AT WORK? 1 YES 2 NO fectory, office  ne time, data and place, and du ny opinion, death occured at th	6 Other (Specify)  28d. DESCRIBE HOW INJ  28f. LOCATION (Street and City or Town, State)  e to the cause(e) and manne time, date and place, and IMBER	d Number or Rural F er as stated. due to the cause(a 29d. DATE SIGNED	) and manner as stated. (Month, Day, Year)
COMPLETED BY	EXAMINER? CLEARED BY  1 YES 2/ NO  27. MANNER OF DEATH  1 X Netural 5 Pending Investigation 3 Suicide 6 Could not be determined  29e. CERTIFIER (Check only one)  2 MEDICAL EXAMIN	28e. DATE OF INJURY (Month, Dey, Year)  28e. PLACE OF INJURY building, etc. (Special Sicial Street of the best of my knowners on the basis of examination of the basis of	26b. TIME OF INJURY M  — At home, farm, street, 1  ledge, death occurred at the n and/or investigation, in m	IER: Nursing Home 6 Residence 28c. INJURY AT WORK? 1 YES 2 NO factory, office  The time, data and place, and du ny opinion, death occured at th  29c. LICENSE NU 16397(	6 Other (Specify)  28d. DESCRIBE HOW INJ  28f. LOCATION (Street and City or Rown, State)  e to the cause(e) and manne e time, data and place, and IMBER  (NY)	or as stated.  due to the cause(a  29d, DATE SIGNED	) and manner as stated. (Month, Day, Year) 7 / 9 3
BE COMPLETED BY	EXAMINER? CLEARED BY  1 YES 2 NO  27. MANNER OF DEATH  1 X Neturni 2 Accident 3 Suicide 4 Homicide  29a. CERTIFIER (Check only 1 CERTIFYING PHY ONe) 2 MEDICAL EXAMINE  29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON W	28a. DATE OF INJURY (Month, Day, Year)  28a. PLACE OF INJURY building, etc. (Special Sician)  SICIAN: To the best of my know NER: On the basis of examination  ER	29b. TIME OF INJURY M  — At home, farm, street	IER: Nursing Home 6 Residence  28c. INJURY AT WORK? 1 YES 2 NO factory, office  re time, date and place, and du ny opinion, death occured at th  29c. LICENSE NL 163970  NATIONAL N	6 Other (Specify)  28d. DESCRIBE HOW INJ  28f. LOCATION (Street and City or Rown, State)  to the cause(a) and manner time, date and place, and (NY)  IAVAL MEDICA	er as stated.  due to the cause(s  29d, DATE SIGNED  3 / 1  L CENTER	) and manner as stated. (Month, Day, Year) 7 / 9 3
BE COMPLETED BY	EXAMINER? CLEARED BY  1 YES 2 NO  27. MANNER OF DEATH  1 X Netural 5 Pending Investigation 3 Suicide 6 Could not be determined  29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINED  29b. SIGNATURE AND XITLE OF CERTIFIER  4	28a. DATE OF INJURY (Month, Day, Year)  28a. PLACE OF INJURY building, etc. (Special Sician)  SICIAN: To the best of my know NER: On the basis of examination  ER	26b. TIME OF INJURY M  — At home, farm, street, 1  ledge, death occurred at the n and/or investigation, in m  ATH (ITEM 27) (Type, Print)  JSNR  ATURE	IER: Nursing Home 6 Residence  28c. INJURY AT WORK? 1 YES 2 NO factory, office  re time, date and place, and du ny opinion, death occured at th  29c. LICENSE NL 163970  NATIONAL N	6 Other (Specify)  28d. DESCRIBE HOW INJ  28f. LOCATION (Street and City or Rown, State)  e to the cause(e) and manne e time, data and place, and IMBER  (NY)	er as stated.  due to the cause(s  29d, DATE SIGNED  3 / 1  L CENTER	) and manner as stated. (Month, Day, Year) 7 / 9 3
BE COMPLETED BY	EXAMINER? CLEARED BY  1 YES 2 NO  27. MANNER OF DEATH  1 X Neturni 5 Pending Investigation 3 Suicide 6 Could not be determined  29a. CERTIFIER (Check only 1 CERTIFYING PHY ONe) 2 MEDICAL EXAMIN  29b. SIGNATURE AND TITLE OF CERTIFIER  30. NAME AND ADDRESS OF PERSON WHILTON HOSANNAH	28a. DATE OF INJURY (Month, Dey, Year)  28a. PLACE OF INJURY building, etc. (Special Sicial Street of Mark	29b. TIME OF INJURY M  — At home, farm, street, 1/1/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2	IER: Nursing Home 6 Residence  28c. INJURY AT WORK? 1 YES 2 NO factory, office  re time, date and place, and du ny opinion, death occured at th  29c. LICENSE NL 163970  NATIONAL N	6 Other (Specify)  28d. DESCRIBE HOW INJ  28f. LOCATION (Street and City or Rown, State)  to the cause(a) and manner time, date and place, and (NY)  IAVAL MEDICA	er as stated.  due to the cause(s  29d, DATE SIGNED  3 / 1  L CENTER	) and manner as stated. (Month, Day, Year) 7 / 4 3



RACE — American Indian, Black, White, etc.

white

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG. NO 2. DATE OF DEATH MONTH 3. TIME OF DEATH Daldron 445 93 Q.M 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 12-17-07 MISSOURI DAYS 1 M 2 K F MONTHS HOURS MIN. 85 YRS. 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Washington Adventist Hospital Montgomery Takoma 10c. CITY, TOWN OR LOCAR 10d. INSIDE CITY akoma tark 1 YES 2 NO 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20912

1 Never Married 2 Married IF YES, GIVE WAR OR DATES 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION (Specify only highest grade complete

16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)

SCHOOL TEACHER

PUBLIC SCHOOLS

16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last) F. WILLIAM

Elementary/Secondary (0-12)

4. SOCIAL SECURITY NUMBER

DIRECTOR

BY FUNERAL

COMPLETED

BE

2

notified at once

pe

must

examiner

10a STATE

MD

600

11. MARITAL STATUS

215-38-4415

9a. FACILITY NAME (If not institution, give

RESIDENCE OF DECEDENT

Elm

10s. STREET AND NUMBER

COOK

College (1-4 or 5+)

FOUR

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 ZNO

16. MOTHER'S NAME (First, Middle, Maiden Surname) MYRTLE BONER

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-

If yes, specify Cuban, Maxican, Puarto Rican, etc.)

Specify.

1 TESX NO

19a. INFORMANT'S NAME (Type/Print) CLIFFORD WALDRON 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code)

n. Do not enter the mode of dying, such as cardiac or reepiratory arrest,

SAME AS 10 e 20b. PLACE AND DATE OF DISPOSITION (Name of

20c. LOCATION -- City or Town, State DATE

FT' COMPAGN CEMETERY 3/25/93 BRENTWOOD

20s. METHOD OF DISPOSITION
14S Buriel 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL DESWICE LICENSEE

22. NAME AND ADDRESS OF FACILITY TAKOMA FUNERAL HOME INC 254 CARROLL N.W. WASHINGTON, D.C. 20012

Mulin	1002gu
	s, or complications that crused the deal
IMMEDIATE CAUSE (Final	/1

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

Sequentisity list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury that initiated events resulting in deeth) LAST

disesse or condition

resulting in death)

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	2
CEREBRAL VASCULAR DISEASE.	

4a. WAS AN AUTOPSY 1 TYES 2 00

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO

Interval Between

Onset and Death

25. WAS CASE REFERRED TO MEDICAL 1 TES 2 NO

26. PLACE OF DEATH (Check only one)

Inpatient 2 ER/Outpatient	3 🗆 DOA	4 I No	ER: ursing Home 5 - Residence	6 Other (Specify)
28a. DATE OF INJURY	28b. TIN	E OF	28c, INJURY AT	28d. DESCRIBE HOW INJURY

27. MANNER OF DEATH 1 Netural
2 Accident

296. SIGNATURE AND TITLE OF CERTIFIER

3 Suicide

4 Homicide

29e, CERTIFIER . In

5 Pending 8 Could not be determined

CEREBRAL

28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY	OCCURED
1 YES 2 NO		

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

14	CENTIFYING PRISICIAN: To the deat of my knowledge, death occurred at the time, data and placa, and due to the cause(a) and manner as atlated.
2 [	MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated.

11100	Jones X	. 1110
AME AND ADDRESS OF	E DEDOON WHO COMOLETED CALLES	OF DEATH OFFILE

HOSPITAL:

29c. LICENSE NUMBER D24245. 29d. DATE SIGNED (Month, Day, Year) 3/22/93

ALAN DIAMOND SPRING 1106 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

SILVER SPRING ST.

20910

filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should by or removal. urs after death. Page 6 may be retained by the hospital or attending physician. medicai ŏ the mental hysician and completely remarks the prior to burlal, cremarks OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within event, traumatic other 6 the atlen Mental h injury, o signed by the amy shows Deel of o has b. Dept. s 23 Item : the State certificate b This o marked,

MEDICAL CERTIFICATION

PHYSICIAN:

BY

BE COMPLETED

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MPORTANT

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, After DIRECTOR: hours after R

> who Davidson Randall DHMH-16 Rev 1/89



Pages 1, 2, 3 should

BE

2

ITENDING PHYSICIAN: The law requires that the death certificate be executed within 2 wurs after death. Page 6 may be retained by the hospital or attending physician.	IRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE SCRIP	TO THE FUNERAL DI	be filed within 72 ho	IMPORTANT: If ite

09784 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 2. DATE OF DEATH MONTH 1. DECEDENT'S NAME (First, Middle, Last) ZALIE VALENTINE WARNER 3. TIME OF DEATH 45 W 93 24 Warner A 8. AGE (In yrs. last birthday) 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign MONTHS DAYS HOURS 3-9951 060-0 1 M 2 F YRS. Minn 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Brooke 61016 Olne Monta DIRECTOR RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10b. COUNT 10d. INSIDE CITY LIMITS? MARYLAND MONTGOMERY SILVER SPRING 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 415 PENWOOD ROAD 20901 **USA** 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Merried 2 Merried Specify: BY 3 Widowed 4 Divorced WHITE ETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)

FCONOMIT 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) ECONOMIST Elementery/Secondary (0-12) College (1-4 or 5+) US. Dept DEPT. OF COMMERCE COMPL 4 18. MOTHER'S NAME (First, Middle, Meiden Surname) 17. FATHER'S NAME (First, Middle, Last) WARNER EDWIN L. IDA LaFEBORE 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, INFORMANT'S NAME (Type/Print) D. 415 PENWOOD ROAD, SILVER SPRING, MD 20901 RICHARD WARNER 20c. LOCATION — City or Town, State
ROCKWILLE 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or METHOD OF DISPOSITION 2 Cremetion 3 Removal from State PARKLAWN CEMETERY 4 Donation 5 Other (Specify) 22PRMENO ASPRES OF COUNTINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901 21. SIGNATURE OF FUNERAL SERVICE LICENSEE teven 23. PART I. Enter the diseases, or complications that caused the dasth. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Batween RESISTANT PNOLMONIA METHICILLIN **Onset and Death** IMMEDIATE CAUSE (Final disease or condition TAPHY LOCOCCAL resulting in death) **OUE TO (OR AS A CONSEQUENCE OF):** CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if sny, lasding to immedista cause. Enter UNDERLYING CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to dasth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF OEATH (Check only one) **EXAMINER?** OTHER:

Nursing Home 5 □ Residence 8 □ Other (Specify) Inpetient 2 - ER/Outpetient 3 - DOA 1 YES 2 NO 27. MANNER OF DEATH 28a, DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide COMPLETED 8 Could not be 4 Homicide 29e. CERTIFIER

Thouse past 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(e) end menner se stated.

2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(a) and menner ee stated.

29c. LICENSE NUMBER

3370C

HOWE 32. REGISTRAR'S SIGNATURE
Juna Daydon Bandalle

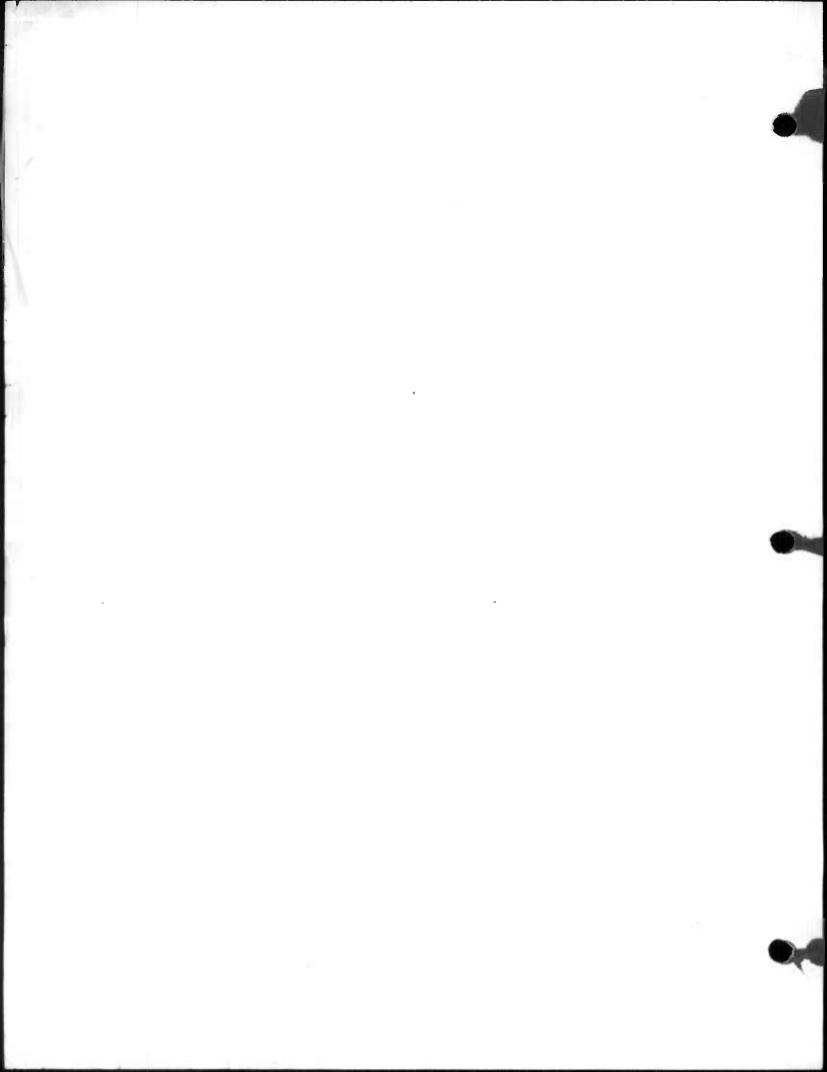
PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print)

M

29b. SIGNATURE AND TITLE OF CERTIFIER

TEdlowe

29d, DATE SIGNED (Month, Day, Year)



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	by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
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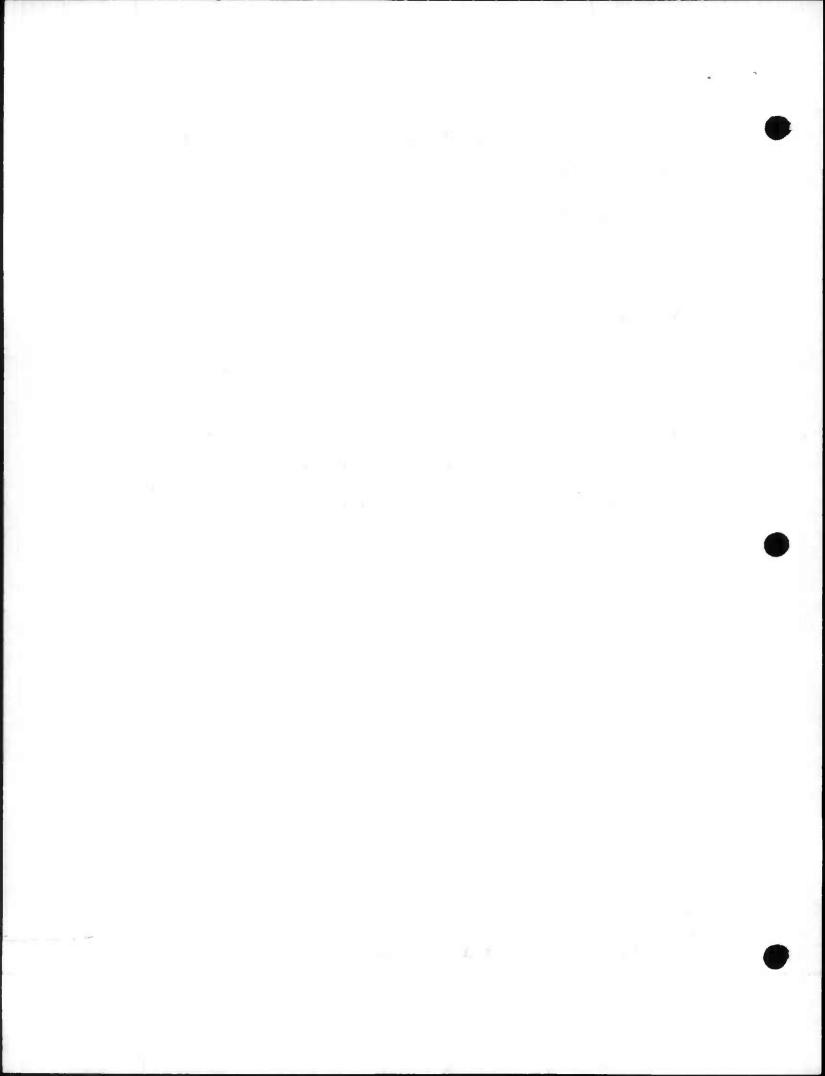
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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THE MAY IN THE LAW FEQUIES THAT THE DESIGN CELLINGARE DE EXECUTED WITHIN 24 HOURS ATTEL DESIGN. MAY BE RETAINED BY THE HOSPITAL OF ATTENDING	me the function has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the	45	
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.	93 (	9785
GEORGE MERRITTE WENTZ	2. DATE OF DEATH DAY	1992	3. TIME OF DEAT

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTM CERTIFICATION	ENT OF HEALTH AND	MENTAL HYGIENE REG. NO.	J	33703
1 1		GEORGE MERRITTE WENTZ		2. DATE OF DEATH	YEAR	3. TIME OF DEATH
	George 1	M. Wentz		03 24	1993	12:45 P H
			UNDER 1 YEAR IF UNDER 24 MRS. ITHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	Coun	HPLACE (State or Foreign try)
	9s. FACILITY NAME (If not institution, give street	t and number) 9b.	CITY, TOWN OR LOCATION OF D		9c. COUNTY OF I	DEATH
DIRECTOR	Crofton Convales	cent Center C	roFtoN		Anne	Arundel
RE	10a. STATE 10b. COUNTY		WN OR LOCATION			10d. INSIDE CITY LIMITS?
	Maryland Anne /	Arundel Sev	erna Park		10a CITIZEN OF	1 ☐ YES 2 🂢 NO
FUNERAL	707 Shore Road		21146		United	
I S	11. MARITAL STATUS	2. WAS DECEDENT, EYER IN U.S. ARMED FORCES? 1 YES 2 NO	13. WAS DECENDENT OF HISPAI If yes, specify Cuben, Mexics			E — American Indian,
BY I	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES	1 TES 2 X NO Specif		Spec	olly:
ED 8	15. DECEDENT'S EDUCAT		AL OCCUPATION	16b. KIND OF BUSIN		nite
1	(Specify only highest grade con Elementary/Secondary (0-12)	(Give kind of work life. Do NOT use ret	done during most of working	IOU. KIND OF BUSIN	ESSIMDOSTRI	
COMPLET	7	O Chief mu	sician	U.S. Nav	/ y	
ő	17. FATHER'S NAME (First, Middle, Last)	/		ME (First, Middle, Maiden Su		
BE	Ambrose Tillro		MACY	JAME S		
5	G. Robinson Wentz		PRESS (Street and Number or Rural			11146
	20e. METHOD OF DISPOSITION	20h DI ACE AND DATE OF DI	e Road, Severr		TION - City or To	
	XXBurial 2 Cremation 3 Remova 4 Donation 5 Other (Specify)	cemetery cremetory or other r	pis. Cem. 03-2	7-93 Wald	dorf, Ma	
	M GIBNATURE OF FUNERAL SERVICE LICEN	SEE	22. NAME AND ADDRESS OF FA The Huntt Fune	CILITY		ti y i a iiu
-	Mark & Brot	nawn Cuu M00053	P.O.Box 156 Wa	ral Home, I	nc.	0604
	23. PART/i. Enter the diseases, or com	pplications that caused the death. Do not e				Approximate
	shock, or heart failure. Lis	t only one cause on each line.				interval Between Onset and Death
	disease or condition resulting in death)	Connex time	Host Fin	lune.		
	resoluting in death) . a	DUE TO (OR AS J CONSEQUENCE DF):	110971 141	W.C		
8	Sequentially list conditions, b					
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONSEQUENCE OF):				i
[윤]	CAUSE (Disease or injury that initiated events	DUE TO (DR AS A CONSEQUENCE OF):				<u> </u>
E	resulting in death) LAST					ļ
	PART II. Other aignificant conditions of	contributing to death but not resulting in the	so underlying onus alves in	Part I. 24a, WAS AN AU		
CAL	Coronary An	teny Disease	e underlying cause given in	PERFORME		b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC	- Coronary Nr.	Torig Wisease		1 _ YE\$ 2 X	] NO	OF DEATH?
≥				—		1 TES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH (Ch	eck only one)		
PHYSICIAN:			HER: Nursing Home 5 Residence			
둦	27. MANNER OF DEATH	28s. DATE OF INJURY (Month, Day, Year) 18JURY		28d. DESCRIBE HOW INJ	URY OCCURED	
BY F	1 Natural 5 Pending 2 Accident Investigation	(month, say, roar)	M 1 YES 2 NO			
	3 Suicide 6 Could not be 4 Homicide determined	26s. PLACE OF INJURY — At home, farm, atreet building, etc. (Specify)	t, factory, office	281. LOCATION (Street and City or Yown, State)	I Number or Rural	Route Number,
COMPLETED	(Check only	N: To the best of my knowledge, death occurred at On the basis of sxamination and/or investigation, in				a) and manner on stated
	296. SIGNATURE AND TITLE OF CERTIFIER					
H	(A) R	( mo	29c, LICENSE NUI		DATE SIGNED	D (Month, Day, Year)
유	30. NAME AND ADDRESS OF ERSON WHO C	COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print	1)	-	- 0/2	1117
	1684 Village	Shean Crots	1 100 0-	14		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE Julia Davidon Randon				
1 1	7 7 00	Lannan Make Mathers	•			



24 nours after death. Page 6 may be retained by the host	filled in by the funeral director, page 5 should be detache	on, or removal.	rile event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	or Item 23 shows any injury, or other trauma
TO THE HOSPITAL OR ATTENDING PHY	TO THE FUNERAL DIRECTOR: After this	be filed within 72 hours after death with	IMPORTANT: If item 28 is marked,

STATE OF MARYLAND / DEPARTMEN	NT OF	HEALTH	AND	<b>MENTAL</b>	HYGIENE
CERTIFICAT	TE OI	F DEAT	TH		REG. NO.

	1 - STATE OF MARYL REGISTRAR	AND / DEPARTI			MENTAL HYGIEN		0,7,00
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH	-	3. TIME OF DEATH
		ITELEY			7. DATE OF BIRTH	4	93 8:40AM M
	4. SOCIAL SECURITY NUMBER $\begin{array}{c ccccccccccccccccccccccccccccccccccc$	111	NTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 12-13-19		BIRTHPLACE (State or Foreign Country)  Maryland
	9a. FACILITY NAME (If not institution, give street end number)		b. CITY, TOWN O	R LOCATION OF DE			Y OF DEATH
TOR	William Hill Health Care		Easto	n		Tal	lbot
FUNERAL DIRECTOR	Maryland Talbot	10c. CITY, 1	OWN OR LOCAT		рре		10d. INSIDE CITY LIMITS?
0	10a. STREET AND NUMBER		101	ZIP CODE	-PPC	10g CITIZEI	1 YES 2 NO
ERA	Bruceville Road			21673		US	
NO.	11. MARITAL STATUS 12. WAS DECEDENT EVER	N U.S. ARMED			IIC ORIGIN? (Specify Yen, Puerto Ricen, etc.)	e or No- 14	I. RACE — American Indian, Black, White, etc.
BY	1 Never Merried 2 Merried IF YES, GIVE WAR OR C	DATES		2 NO Specify			Specify: White
	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S US	UAL OCCUPATIO	N et of working	16b. KIND OF BI	ISINESS/INDUS	
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+)	Ille. Do NOT use r	etired.)				
M	6 17. FATHER'S NAME (First, Middle, Last)	Housewi	tre	18. MOTHER'S NA	ME (First, Middle, Meide	Surname)	
BE C	Robert T. Knox				Mullik:		
10 B	19e. INFORMANT'S NAME (Type/Print)		The second second		Route Number, City or To		
-	G. Allen Whiteley				ston, MD		
		b. PLACE AND DATE Of cemetary, crematory or Vindy Hi]					ty or Town, State
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	Indy MI	22. NAME AN	D ADDRESS OF FA	CILITY		
	NOHN R. MERCER	N CESP	Newn	am Fune	eral Home	e, P.A	A. ston. MD
	23. PART I. Enter the diseases, or complications that cause shock, or heart fellure. List only one cause on	d the death. Do not	enter the mo	de of dying, suc	h es cardiec or ree	piratory srres	Approximete
	WHITE OF THE CONTRACT OF THE C		00	'00 -			Onset and Death
	resulting in death)  DUE TO (OR AS	A CONSEQUENCE OF):	Pier	ulla	tion		< 10 mun
z	disease or condition resulting in death)  DUE TO (OR AS	noscle	rotic	Rea	it du	2000	Uncertai
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	A CONSEQUENCE OF):					
임	CAUSE (Disease or injury C.	A CONSEQUENCE OF):					
E	resulting in deeth) LAST						
AL CI	PART II. Other significant conditions contributing to death	but not resulting in	the underlying	g ceuse given in			24b. WERE AUTOPSY FINDINGS
SC	agheiner &d	weake			1 YES	2 NO	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ME	-						1  YES 2  NO
AN:	25. WAS CASE REFERRED TO MEDICAL		26 84	ACE OF DEATH (Ch			
SICI	EXAMINER?  1 YES 2 NO 1 Inputtent 2 ER/Ou		тнен:		6 Other (Specify)		
PHYSICIAN: MEDIC	27. MANNER OF DEATH 28s. DATE OF INJURY	28b. TIME	OF 28c, INJ		28d. DESCRIBE HOW	INJURY OCCU	RED
BY	1 Natural 5 Pending 2 Accident Investigation			rES 2 NO			
COMPLETED	3 Suicide 6 Could not be determined 28e. PLACE OF INJUR	IY — Al home, farm, str scify)	eet, factory, offic	•	28f, LOCATION (Stree City or Town, Stat		· Rural Route Number,
PLE	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my kno	wledge, death occurred	at the time, date	end place, end due	to the cause(s) end m	enner as stated	J.
OM	one) 2 MEDICAL EXAMINER: On the basis of examineti	on end/or investigation,	in my opinion, d	eath occured at the	time, date and place,	and due to the	cause(e) end manner ee stated.
BE C	296. SIGNATURE AND TITLE OF CERTIFIER  ROBERT W. Transper	115		29c. LICENSE NUI		1150	SIGNED (Month, Day, Year)
70	Robert W. Trever, 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF O		rint)	D10938		3.	-15-93
	Robert W. Trever, M.D.,			atewav	Easton	MD 2	21601
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIG	NATURE			2,000,001		
- 6	MAR 1 7 1993	American					

de l'andre

TO THE FIGURATION PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

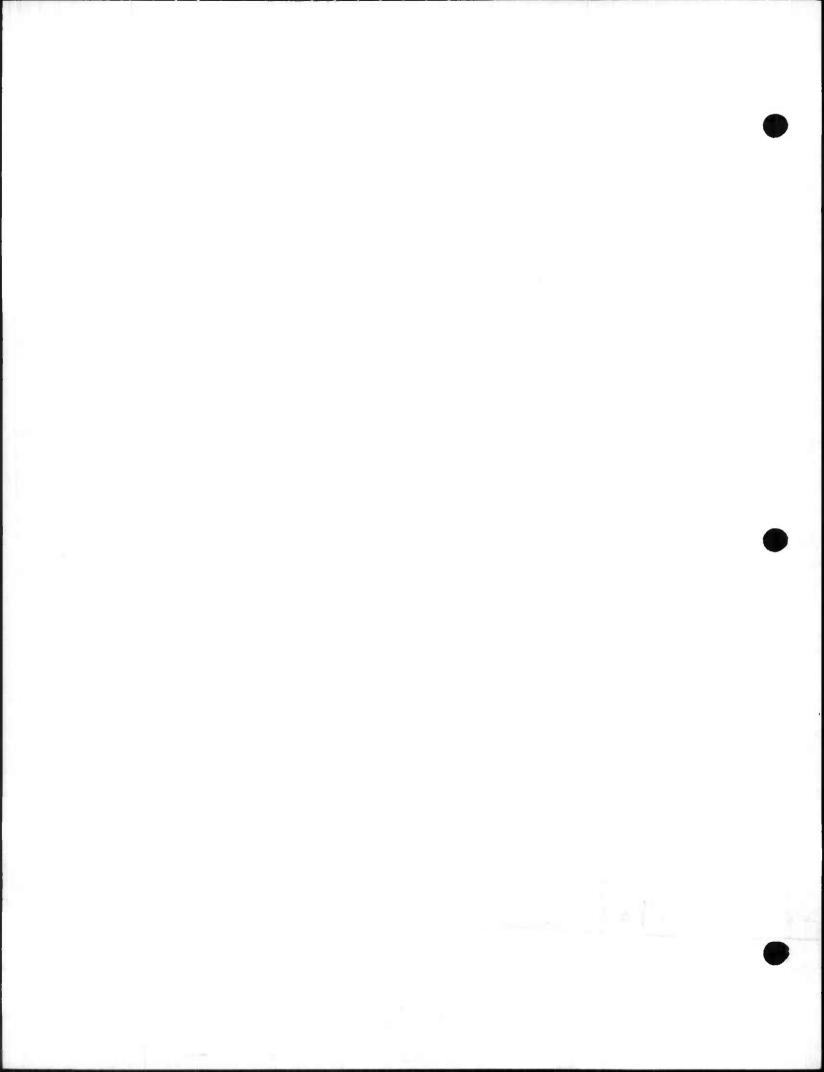
TO THE HUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be fine mith the State Dept. of Health and Mental Hygiens prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - FOR STATE REGISTRAR

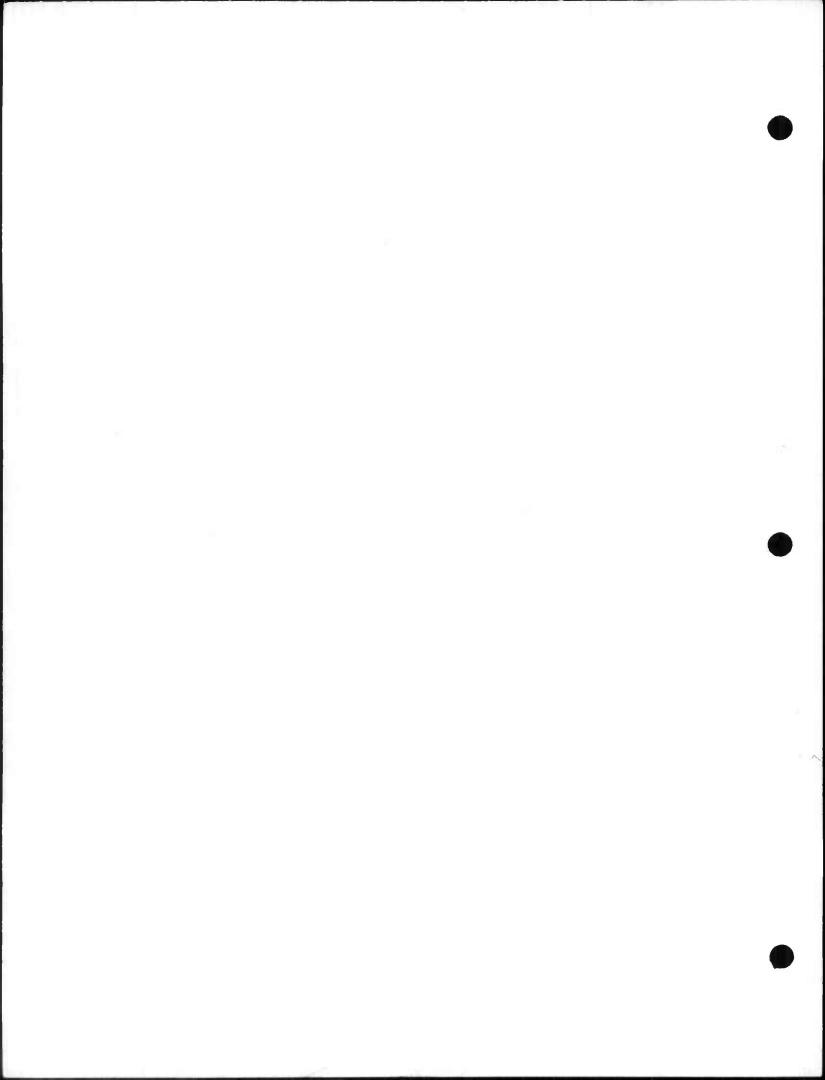
## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REGISTRAR		CERI	FICALE (	OF DEATH		REG. NO		
	1. DECEDENT'S NAME (First, Middle, Last)		1 1/		-	2. DATE OF	DEATH D		3. TIME OF DEATH
	Lillian	Α.	Witter	5		3-	19		3 0020 AM
1	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthd			7. DATE OF	витн		BIRTHPLACE (State or Foreign
	217-32-4813	1 M 2 F	56 YR	MONTHS D	YS HOURS MH.	(Month, D. MARCH		1937	WASHINGTON, DC
	Se. FACILITY NAME (If not institution, give s	treet and number)		96. CITY, TO	WN OR LOCATION OF D		,		Y OF DEATH
E E	HOLV CDOCC HO	CDTMAT		ОТ	THEN ADDITA			1/0	umaavæav
18	HOLY CROSS HO	SPITAL		1 5.1	LVER SPRIN	NG .		MO.	NTGOMERY
DIRECTOR	10a. STATE 10b. COUNTY	1	10c.	CITY, TOWN OR L	OCATION				10d. INSIDE CITY
E	MARYLAND MON	TGOMERY	RO	CKVILLE					LIMITS?
A	10s. STREET AND NUMBER		1 100	ORVILLE	101. ZIP CODE			10g. CITIZE	N OF WHAT COUNTRY?
FUNERAL	4500 ASPEN H	TII DOAD			2005	2		,,	
2	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. ARMED	13. WAS	20853 DECENDENT OF HISPA		Concilly Visa		SA I. RACE — American Indian.
	1 Never Married 2 Married	FORCES? 1	YES 2 NO	If yo	s, specify Cuben, Mexico	an, Puerto Rica	n, etc.)	0.10	Black, White, etc.
ВУ	3 Divorced	W 1ES, GIVE W	AR OR DATES	''	YES 2 NO Specif	y:			Specify: WHITE
	15. DECEDENT'S EDU		16a. DECEDEN	T'S USUAL OCCU	PATION	16b, KII	ND OF BUS	SINESS/INDUS	STRY
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+	His Da MC	of work done durin T use retired.)	g most of working	10410 140			
굽	12		' HOMEN	(AKED					
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)			HILLIN	18. MOTHER'S NA	ME /Elmt Midd	So Mairing	Summer)	
Ш	SYDNEY WAL	TED			- Company of the Company	uni (i mai, imioo		,	
0	19a. INFORMANT'S NAME (Type/Print)	IER	40b MAR	NC ADDRESS (D	ETHEL	0	MILI		
	A CONTRACTOR OF THE PROPERTY O	TD C							
	ROGER W. WITT 204, METHOD OF DISPOSITION	ERS			ILL ROAD,				
1 3	1 X Burial 2 Cremation 3 Rem	oval from State	20b. PLACE AND DA cemetery, crematory	or other place)		DATE	20c. LO	CATION — CH	ly or Town, State
	4 Donation 5 Other (Specify)	7	FT. LINCO			3/22	BRE	ENTWOO	D, MD
1 1	21. SIGNATURE OF FUNERAL SERVICE LIC	enser///	201	22. NAN	E AND ADDRESS OF FA	KCILITY			
	Mak 1	/illa	lla	FRANC	IS J. COLI	LINS FU	JNERA	L HOM	E, INC.
	23. PART I. Enter the diseases, or o	complications that	caused the death. D	o not enter the	mode of dying suc	h as cardiac	or meni	STI.	SP MD 20901
1 4	shock, or heart failure.	List only one cau	se on aach line.		mode of offing, ode		or rospi	ratory arros	Interval Between
1 1	iMMEDIATE CAUSE (Final disease or condition		t	+					Onset and Death
	resulting in death)	. CECN	a offi	acces-					2-1 hrs.
	DUE TO (OR AS A CONSEQUENCE OF):								
o	Sequentially list conditions,	DUE TO	Q AS A CONSEQUENCE	OD:					yeare
<del> </del>	if any, leading to immediate cause. Enter UNDERLYING		4						"
[윤]	CAUSE (Disease or injury that initiated events	DUE TO	OR AS A CONSEQUENCE	OFI-					
E	resulting in death) LAST								j
CERTIFICATION		1							
	PART II. Other significant condition	s contributing to	death but not resulting	g in the under	lying ceuse given in	Part I. 24	n. WAS AN		24b. WERE AUTOPSY FINDINGS
EDICAL						- I	PERFOR		MAILABLE PRIOR TO COMPLETION OF CAUSE
						—   ''	YES 2	₩0	OF DEATH?
Σ						-			1 TES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL								
$\overline{2}$	EXAMINER?	HOSPITAL:	W - 0.11/2	OTHER:	6. PLACE OF DEATH (Ch	eck only one)			
\ X	1 🗆 YES 2 🗇 ÑO		ER/Outpatient 3 DO	4 Nursing	Home 5 - Residence				
표	27. MANNER OF DEATH  1 Netural 5 Pending	28a. DATE OF (Month, De		TIME OF 280 INJURY	. INJURY AT WORK?	28d. DESCRI	BE HOW II	NJURY OCCU	RED
``	2 Accident Investigation				YES 2 NO				
ED	3 Suicide 6 Could not be	28e. PLACE Of building,	INJURY — At home, fam etc. (Specify)	n, street, factory,	office	28f. LOCATIO	ON (Street a	and Number or	Rurel Route Number,
	4 Homicide determined						,		
COMPLET	29e. CERTIFIER (Check only 1 CERTIFYING PHYSIC	CIAN: To the best of	my knowledge, death occ	urred at the time,	date and place, and due	to the causeli	s) and man	ner as stated	
N N									cause(s) and manner as stated.
8	296_SIGNATURE AND TITLE OF CERTIFIER								
	The or Centries	J'harl	MD		29c. LICENSE NUI	wider		29d. DATE S	SIGNED (Month, Day, Year)
8									1.0107
TO BE	Much f.	O COMPLETES SI		-	10186	9 C		. 2	119/23
0	30. NAME AND ADDRESS OF PERSON WHO		E OF DEATH (ITEM 27) (I	pe, Print)	20186	0 0	^		119/23
0	30. NAME AND ADDRESS OF PERSON WHI	u me	E OF DEATH (ITEM 27) (I	pe, Print)	PENE	S	2	2 A	20902



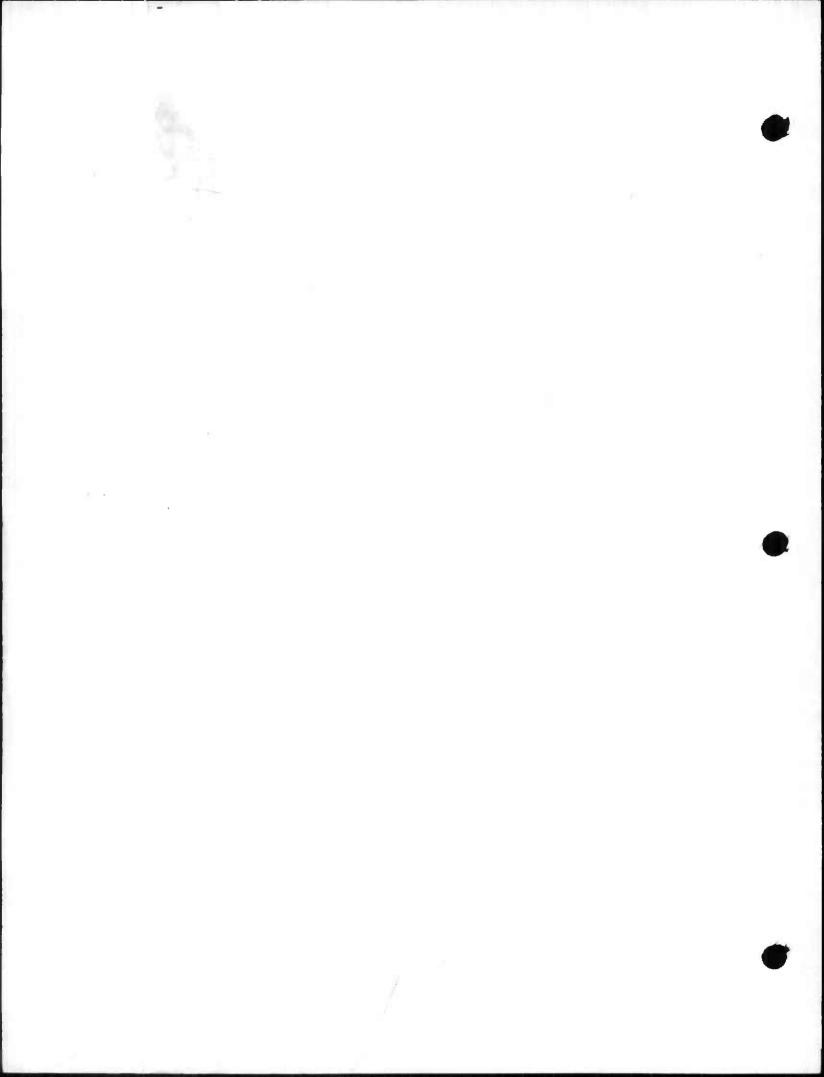
	BALTIMORE, MARYLAND 21215-0020	SICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	ion, or removal.	he medical examiner must be notified at once.	
@ 8+	MINISTON OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OF A LEADING PHYSICIAN: The law requires that the death certificate be executed within 2	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

	1 - STATE REGISTRAR	STATE OF MARYLAND / DECER	EPARTMENT OF I		MENTAL HYGIEN		0 ) 1 0 0
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH
	GASTON DE	FOIX WILSO	0~		MARCH 1	**	93 3:45 P.M
		5. SEX 6. AGE (In yrs. lest birt		IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	7 1	BIRTHPLACE (State or Foreign Country)
	011 10 0 121	x -   3/	YRS. MONTHS DAYS	HOURS MIN.	JAN. 29, 193	35 S	OUTH CAROLINA
m	9e. FACILITY NAME (If not institution, give street	et end number)	9b. CITY, TOWN	OR LOCATION OF DE	НТА		OF DEATH
DIRECTOR	6206 20TH PLACE		HYATT	SVILLE		PRINC	E GEORGES
3EC	10e. STATE 10b. COUNTY	10	Oc. CITY, TOWN OR LOCA	TION			10d. INSIDE CITY
	MARYLAND PRINCE	GEORGES	HYATTSV	ILLE			1 YES 2 NO
AL	10e, STREET AND NUMBER		10	. ZIP CODE		10g. CITIZE	N OF WHAT COUNTRY?
FUNERAL	6206 20TH PLACE			20782		US.	A
FUI	11. MARITAL STATUS  1 Never Merried 2 X Merried	2. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 Y YES 2 NO		ENDENT OF HISPANI ecify Cuben, Mexican	IC ORIGIN? (Specify Yee		. RACE — American Indian, Black, White, atc.
ВУ	3 Widowed 4 Divorced	FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		2 NO Specify:			Specify:
ED	15. DECEDENT'S EDUCAT		DENT'S USUAL OCCUPATION		16b. KIND OF BUS	SINESS/INDUS	WHITE
ET	(Specify only highest grade col	mpleted) (Give ki life, Do life, Do	sind of work done during mo NOT use retired.)	st of working			577
MPL	12	SALES	PERSON -CLO	OTHING	CLOTH	LNG ST	ORE
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NAM	ME (First, Middle, Maiden	Sumame)	
BE	YORK WILSON			MINN			
6	19e. INFORMANT'S NAME (Type/Print)		AILING ADDRESS (Street				
	ELSA A. WILSON		06 20TH PLA		TSVILLE, MA		
	20a. METHOD OF DISPOSITION  1\( \) Burlal 2  Cremation 3  Remova  4  Donation 5  Other (Specify)  \qu						y or Town, State
7	21. SIGNATURINOF FUNERAL SERVICE LICEN	BEE	22. NAME AI	ND ADDRESS OF FAC	ILITY		MARYLAND
	1 1	0,0	/ FRANCI	S J. COL	LINS FUNER	AL HO	ME, INC.
	23. PART I. Enter the diseases, or con	oplications that caused the death	Do not enter the ma	VIVERSITY	BLVD.W.	SIL.SI	PR. MD. 20901
	shock, or heart failure. Lis IMMEDIATE CAUSE (Final	t only one cause on each line.	DO NOT WHAT THE THO	de or dying, such	as cardiec or respi	ratury erres	interval Between
	disease or condition	Motostat	ic Pons	toute	00000		Onset and Death
	disease or condition resulting in death) a. Metastatic Prostate Cancer 6 months						6 Walls
Z	Sequentially list conditions, b.						
Ĕ	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONSEQUEN	NCE OF):				
5	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CONSEQUEN	NCE OF:				
CERTIFICATION	resulting in death) LAST						j
	DADT II Other significant and date.						
CAL	PART II. Other significent conditions of	ontributing to death but not resul	iting in the underlying	g ceuse given in F	Part i. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
Ē					1 TYES 2	NO	COMPLETION DF CAUSE OF DEATH?
Σ					_		1 TYES 2 NO
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL		26. PI	ACE OF DEATH (Chec	rk only one)		
Sic		IOSPITAL:	OTHER:	e 5 Residence 6			
Ŧ	27. MANNER OF DEATH	28e. DATE OF INJURY 26	b. TIME OF 28c. INJ	URY AT	28d. DESCRIBE HOW IN	JURY OCCUR	ED
BY	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)		RK? /ES 2 NO			
	3 Suicide 6 Could not be	26a. PLACE OF INJURY — At home, 1 building, atc. (Specify)	farm, street, factory, office	•	281. LOCATION (Street e City or Town, State)	nd Number or	Rural Route Number,
	4 Homicide determined						
COMPLETED		N: To the best of my knowledge, death o					
ő	2 MEDICAL EXAMINER: (	On the besie of examination and/or Inves	stigation, in my opinion, d	eath occured at the ti	ime, date and place, end	due to the c	euse(e) and manner as stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIER	2000	-0.0	29c. LICENSE NUME			GNED (Month, Day, Year)
5	30. NAME AND ADDRESS OF PERSON WHO C	THE STEP CHIEF ST ST ST	771	02897			21/93
	LISA LILIENFI	ELD, MO 7505	NEM HA	MPSHIRE	AVE. LA	NGLE	1 PK, MD 20783
	MAR 22 93	32. HEGISTRAPS SIGNATURE GUARANTE PORT	Lee				



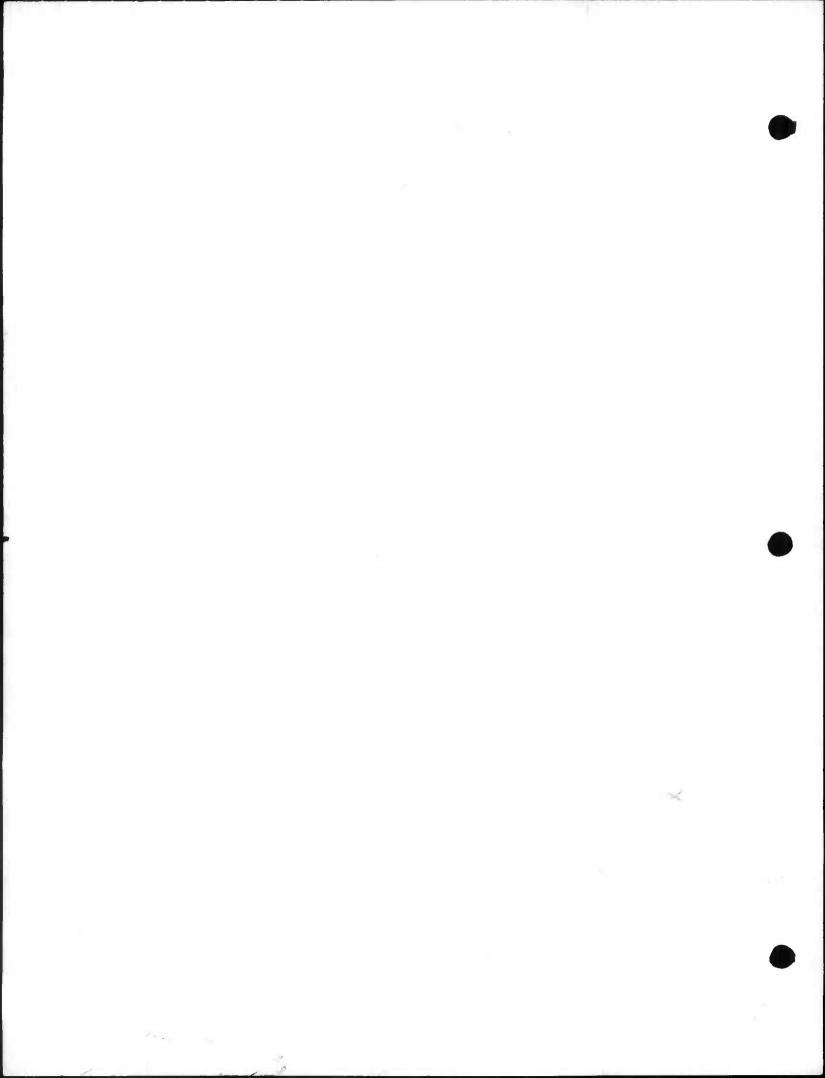
1		F
BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physical in by the funeral director, page 5 should be detached for use as the burial-ion removal.	medical examiner must be notified at once.
	in 24 ety fill	the
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlath and filled within 75 hours after death with the State pent of Health and Merital Hydiene notice to burlath, certained for the burlath and within 75 hours after death with the State pent of Health and Merital Hydiene notice to burlath certained for the burlath.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	REGISTRAR		CENT	IFICA	IE UF	DEATH	R	EG. NO.		
	1. OECEDENT'S NAME (First, Middle, Last)  James	R. A	yers				2. DATE OF I	DEATH DR / Q 3	YEAR: 3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. last birth	ation I make			<del> </del>			M
	219-07 9997	1 ∰ M 2 □ F	, ,	MONTH	DER 1 YEAR IS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF E (Month, De		8. BIRTHPLACE (State or Foreign Country) VA	F
	9a. FACILITY NAME (If not institution, give s	treet and number)		9b. C	ITY, TOWN C	OR LOCATION OF DI			UNTY OF DEATH	_
DIRECTOR	(Home) 323 Alle	ndale St.			Ва	ltimore				
5	RESIDENCE OF DECEDENT									
H H	10a. STATE 10b. COUNTY		10c.		N OR LOCAT				10d. INSIDE CITY LIMITS?	
	Md.			Ва	ltimo	re			1 # YES 2   NO	
<b>₹</b>	100. STREET AND NUMBER 323 Allen	dale St.			101	. ZIP CODE		10g, CI	TIZEN OF WHAT COUNTRY?	
FUNERAL						21229			USA	
5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EN	YES 2 NO		13. WAS DEC	ENDENT OF HISPAI ecity Cuban, Mexica	NIC ORIGIN? (S	pecify Yes or No-	14. RACE - American Indian, Black, White, etc.	
À	3 Widowed 4 Divorced	IF YES, GIVE WAR				NO Specif		,,	Specify:	
ED	15. DECEOENT'S EDUC	CATION	16a, DECEDE	NT'S HEHAI	OCCUBATION	W .	Tab. Ma	D OF BUSINESS/IN	Afr. American	_
I E	(Specify only highest grade	completed)	(Give kin	d of work do OT use retire	ne during mo	st of working	100. Kill			
1	Elementary/Secondary (0-12)	College (1-4 or 5+)	-	tired				Civil S	Service	
COMPLET	17. FATHER'S NAME (First, Middle, Last)			_		18. MOTHER'S NA	ME (First, Middl	e, Maiden Surname)		
	John A	yers					osa J.			
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAJ	LING ADDR	ESS (Street a	nd Number or Rural		-	(ip Code)	_
5	Dorothy Aye	rs				ale St.				
	20a. METHOD OF DISPOSITION	COLUMN TO THE PARTY OF	20b. PLACE AND D			ime of	OATE	20c. LOCATION	- City or Town, State	
	4 Donation 5 Other (Specify)	oval from State	Garris	on Fo	rest	4/1/93		Owings	Mills, Md.	
	21. SIGNATURE OF FUHERAL SERVICE LIC	ENSEE				D ADDRESS OF FA				
	· (eal ()	Orles	1		ES	300 Euta	hers F	uneral H	Iome P.A.	
	23. PART I Enter the diseases, or o	complications that ca	used the death.	Do not en						_
	shock, or heart failure.	List only one chuse	on each line.			. 1			interval Betwe	
	disease or condition resulting in death)	Sandle	cell.	Pron.	11 2	of lun	R		Ture	
	resulting in death)	DUE TO (OR	AS A CONSEQUENCE	CE QF):	/	-			177	
Z	Sequentially list conditions,	b								
CERTIFICATION	if any, leading to immediate	DUE TO (OR	AS A CONSEQUENC	CE OF):						
2	cause. Enter UNDERLYING CAUSE (Disease or injury	C. DISE TO (OR	AS A CONSEQUENCE	SE OF						
Ē	that initiated events resulting in death) LAST	DOE 10 (OR	AS A CONSEQUENC	e orj:						
S		d								
A.	PART ii. Other significent condition	s contributing to dea	ith but not result	ing in the	underlying	g cause given in	Part i. 24s	. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDING AVAILABLE PRIOR TO	IGS
EDICAL							1[	YES 2 NO	COMPLETION OF CAUSE OF DEATH?	Ε
ME							_		1   YES 2 170	
CE	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		ОТН		ACE OF DEATH (Ch	eck only one)			
PHYSICIAN:	1 TYES 2	1   Inpatient 2   ER		DA 4 🗆 I	Nursing Hom	• 5 Healdence	8 Other (Sp	ecify)		
	27. MANNER OF DEATH  1 Militural 5 Pending	28s. DATE OF INJ (Month, Day, 1		TIME OF		RK?	28d. DEŞCRII	BE HOW INJURY OF	CCURED	
BY	2 Accident Investigation	00- PM 405 05 W	Hillery As by d			rES 2 NO				
G	3 Suicide 6 Could not be 4 Homicide detarmined	building, atc.	JURY — At home, fa (Specify)	rm, street,	ractory, offic			N (Street and Numbe wn, State)	er or Rural Route Number,	
	29a. CERTIFIER									_
MPI	(Check only	CIAN: To the best of my								
COMPL			nation and/or investi	gation, in m	ny opinion, d	eath occured at the	time, data and	place, and due to t	the cause(s) and menner as stated.	ı.
BE	296. SIGNATURE AND STILE OF CENTURES	M	D			DIES	WBER 7	29d. DA	TE SIGNEO (Month Day, Year)	
10	30. HAME AND ADDRESS OF PERSON WHI	COMPLETED CAUSE C	of Death (ITEM 27)	(Type, Bright)	0/	ATM.	AND	BATTE	MD	
10	31. DATE FILEO (Morith, Dey, Year)	32. REGISTRAR'S	SIGNATURE			11000 /	101	12101	114	
10	APR - 7 1993	Julia Davido	- Aproposite							



EVITAL RECORDS, P.O. BOX 68760,  BALTIMORE, MARYLAND 21215-0020  SICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  The state has been signed by the attending physician and completely fifted in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State hand hand Hydrope prior to hairst companion, or senation.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,  TO THE CALL OR ATENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after of TO THE CALL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the P. De filed.	IMPORTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF I					EALTH DEAT		MENTAL HYGIEN REG. NO.	E	0 0 0 1 0 0
	1. DECEDENT'S NAME (First, Middle, Last) $Mabel$	0.	Batty		31				2. DATE OF DEATH MONTH 4 3 DA	9 3 YEAR	3. TIME OF DEATH
	217-20-9695	5. SEX	8. AGE (In yrs. lest to 9 5	VRS.	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF BIRTH (Modth-Day Mond 1:2 20	L Chr.	THPLACE 4State or Foreign
Œ	Se. FACILITY NAME (If not institution, give stre			1			R LOCATIO	N OF DE	ATH	9c. COUNTY OF	
DIRECTOR	Seton Hill Man	or Nur	sing Hor	me [	Bal	tin	ore				- 44
RE	10a. STATE 10b. COUNTY			10c. CITY	, TOWN O	R LOCAT	ON				10d. INSIDE CITY LIMITS?
	Maryland 100. STREET AND NUMBER			Ва	ltin						XIX YES 2 NO
RA			#104			101.	ZIP CODE				WHAT COUNTRY?
FUNERAL	1600 Mt. Royal 11. MARITAL STATUS	AVENUE	T EVER IN U.S. ARMI	ED	13. V	MAS DECI		217 FNISPAN	IC ORIGIN? (Specify Yea	USA	
В	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 IF YES, GIVE W	YES 2 NO		- 11	yes, spe		, Maxicar	, Puerto Rican, etc.)	Bia	CE - American Indian, ck, White, etc.
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade or	ATION ompleted)	16a. OECE	EDENT'S	USUAL OC	CUPATIO	N t of working	,	16b. KIND OF BUS	INESS/INDUSTRY	
Z	Elementary/Secondary (0-12)	College (1-4 or 5 -	,				t of working	,	2		
OME	17. FATNER'S NAME (First, Middle, Last)		Hou	user	wife	-	10 100711	SO'C MAG	RE (First, Middle, Maiden )		
	William H. Bro	wn							E L. Nori	,	
TO BE	19a. INFORMANT'S NAME (Type/Print)	<u> </u>	196. 1	MAILING	ADDRESS	(Street ar			oute Number, City or Town		21215
۲	Allen Ringgold		300	05 (	Gran	ada	Ave	enue	Baltin	nore, M	21215 farvland
	20s. METNOD OF DISPOSITION 1 Sp Burial 2 Cremation 3 Remov	rel from State	20b.PLACE AN cemetery, creme	DDATEO	FDISPOSI				1/8/93 20c. LOC		
	4 Donation 5 Other (Specify)	Nece	Pleas		t Re			ere.	TOWS	son, Ma	ryland
	4.	harris			22. F	AME AN	ADDRES	S OF FAC	arity 1	.701 Mc	Culloh St.
	23. PART I. Enter the diseases, or co				Ch	atm	an-I	Jarı	cis F/H E	Baltimo	re, Md2121
CERTIFICATION	ahoćk, or heart feliure. Li iMMEDIATE CAUSE (Finel disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO	OR AS A CONSEQUE	ENCE OF	E E	Reng	J.	No 10	VASCUPAR E	CEANIE CEANIE	Interval Between Onset and Death
MEDICAL	PART II. Other significant conditions	Contributing to	alu	5	n the und	derlying	ceuse gi	iven in F	Part I. 24a. WAS AN / PERFORI	WED?	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
Σ	301	2-16	ement	· C	PACIL	1017	( Hi	0	-		1 TES 2 NO
Ä	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	TROP	1/2/2/	11	-3010	- 1/2/2/	CE OF DE	ATN (Cho	ck only one)		
Sign		HOSPITAL: □ Inpetient 2 □	ER/Outpatient 3		OTHER 4" Hursi		5 Res	idence 8	B ☐ Other (Specify)		
PHYSICIAN:	27. MANNER OF DEATH  1. C. Netural 5 Pending	28a. DATE OF (Month, Di	injury 19, Year) - 1992	28b. TIME	OF	28c. JNJU WOR	RY AT		28d. OESCRIBE HOW IN		
B	2 Accident Investigation			4:3	O Pa		S 2 X		SUBJECT		AT HOME
ETED	3 Suicide 6 Could not be determined	building,	INJURY — At home etc. (Specify)		ireet, facto	ry, office			261. LOCATION (Street at 1600 MT. I	ROYAL A	Number BALTO . N VENUE#104
COMPLET	29e. CERTIFIER (Check only one)  2 MEDICAL EXAMINER:								o the cause(a) and mani ime, date and place, and		(s) and manner as stated.
TO BE C	296. SIGNATURE AND TITLE OF CENTIFIER	lel	My	_			29c. LICEN				D (Month, Day, Year)
-	38. NAME AND ADDRESS OF PERSON WIND	A	e of Oeath (ITEM 2	0	Primi)	Con	+ Ro	lsu	Je 201 Run	dulltown	JMO 21137
	APR 07 1993	32. REGISTRA	S SIGNATURE								



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

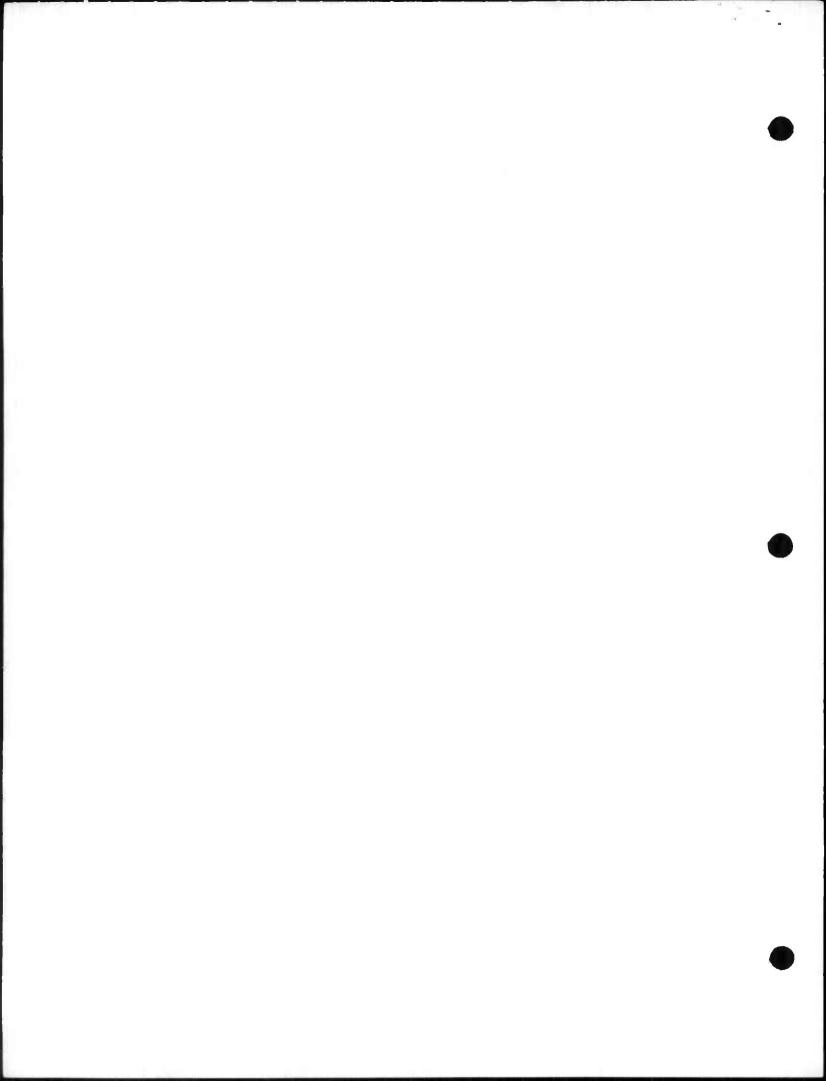
31. DATE FILED (Month, Day, Year)

APR 07 1993

												93	09791
	1 - FOR STATE REGISTRAR	STATE OF !	MARYLAND /	DEPAR	TMEN	T OF H	DEAT	AND I	MENTA	L HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)									OF DEATH			3. TIME OF DEATH
	JANE	E.			BR	OOK	S		MONT 4	2	AY	93	M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	st birthday)		R 1 YEAR	IF UNDER	24 HRS.	7. DATE	OF BIRTH			IPLACE (State or Foreign
	214-64-6301	1 🗌 M 2 💢 F	42	YRS.	MONTHS	DAYS	HOURS	MIN.		h, Day, Year) 2-22-	50	Countr	γ)
	9e. FACILITY NAME (If not institution, give str	eet and number)			9b. CIT	Y, TOWN (	PR LOCATIO	ON OF DE		<u> </u>		JNTY OF D	MD
H	1234 SHERWOOD	AVENUE		BALTIMORE									
DIRECTOR	RESIDENCE OF DECEDENT							_					
H	10e. STATE 10b. COUNTY			10c. CIT	Y, TOWN	OR LOCAT	ION						10d. INSIDE CITY
	MD			BA	LTI	MORI	Ε						TYNES 2 NO
A	10e. STREET AND NUMBER					101	ZIP CODE				10g. CIT	FIZEN OF W	HAT COUNTRY?
ᇤ	1234 SHERWOOD A	VENUE					212	39			υ	J.S.A	A .
FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN			13.	WAS DEC	ENDENT O	F HISPAN	IIC ORIGII	17 (Specify Yes	or No-	14. RACE	- American Indian,
ВУ	1 Never Merried 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE V	YES 2 1	NO				n, Mexical Specify		Rican, etc.)		Speck	t, White, etc.
													BLACK
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of	ATION completed)	16a. DE	CEDENT'S live kind of a Do NOT us	USUAL O	OCCUPATIO	ON st of workin	a	168	. KIND OF BUS	SINESS/IN	DUSTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5	·) Hfe	. Do NOT us	e retired.)	)		•					
N N	12th									2 & P	TEL	EPHO	ONE
	17. FATHER'S NAME (First, Middle, Last)									Middle, Meiden	,		
BE	JAMES YANCY			_						CARRO			
2	19a. INFORMANT'S NAME (Type/Print)									ber, City or Tow			
	Kimany BROOKS							AVE	./B <i>I</i>	ALTIMO	ORE,	MD	21239
	20s. METHOD OF DISPOSITION  1 Muriel 2 Cremetion 3 Remo	val from State	20b. PLACE /	ANDDATE	F DISPO	SITION (Na	me of		OAT			City or To	7.53.5
	21. Signature of Funeral Service Lice		- Arb	utus	Me	MOKI	fal	Par	k	Ar	butu	ıs, I	MD .
	► Honcela	Sta	tell	7	22	. NAME AN	ID ADDRES	S OF FAC	PILITY	/110	l E.	NOF	RTH AVE.
	23. PART I. Enter the diseases, or lo	implications the	t caused the de	ath. Do r	ot ente	r the mo	de of dyle	ng, auct	as cere	diac or respi	ratory ar	reat,	Approximate
	ahock, or heart failure. L IMMEDIATE CAUSE (Final	ist brily one cau	se on each line	l.									interval Between Onset and Death
	disease or condition resulting in death)	Can	er of		PIVI	×							7 4
	rounting in death)	OUE TO	(OR AS A CONSE	DUENCE OF	7:								1 - //
z													
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	OUE TO	(DR AS A CONSE	DUENCE DI	7:								
2	CAUSE (Disease or injury												
# 1	that initiated events resulting in death) LAST	DUE TO	(DR AS A CONSE	DUENCE DI	7):								
5	d.												
- 11	PART II. Other significent conditions	contributing to	death but not r	esulting i	n the u	nderiying	Cause g	Iven in I	Part i.	24a. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
2									724 1	PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
									_	1 TYES 3	ND	1	OF DEATH?
2									-				1 TES 2, NO
AN	25. WAS CASE REFERRED TO MEDICAL					26 PH	ACE OF DE	ATM (Ch.					
PHYSICIAN: MEDICAL		HOSPITAL:	ED/O-dr-ef		OTHE	R:	_						
Ĭ	27. MANNER OF GEATH	28e. OATE DF		28b, TIM		28c. INJ	GX Rai	sidence		r (Specify) CRIBE HOW II		CHIPEO	
	Netural 5 Pending	(Month, D		INJ		WO		I MP	200. 000	CHIOL HOW II	NONT OC	COREO	
à l	2 Accident Investigation 3 Suicide & Could get be	28e. PLACE O	F INJURY — At ho	me, farm, s	treet, fac			140	281 1.00	ATION (Street e	and Mumba	. a. B	auto Mumbas
6	4 Homicide 6 Could not be	building,	atc. (Specify)		,				City	or Town, State)	HUITIUBI	or nurer M	outo Hullion,
COMPLET	290. CERTIFIER A CERTIFYING PHYSIC	AM. To the tree of											
MP M	(Check only one)  2 MEDICAL EXAMINER												
8	29b. SIGNATURE ANO/TITLE OF CERTIFIER			veaugano	in iny	opinion, de				end place, and			
BE	AND TILE OF CERTIFIER	1014.		1			29c. LICE	-	/		29d. DAT	E SIGNEO	(Month, Day, Year)
၀	30 NAME AND ADDRESS OF PERSON WHO	COMPLETED	1				PC	15-	76		P L	1.5	1

DEATH (FEM 27) (Type, Print)

32 ABGUSTANT'S SIGNATURANDESSE



	1 - STATE REGISTRAR	STATE OF MA			ICATE					HYGIENI REG. NO.	E		09192
	1. DECEDENT'S NAME (First, Middle, Last)	E.	BEC	K					2. DATE OF	DEATH &	Y (	931	3. TIME OF DEATH 6:4/A M
	4. SOCIAL SECURITY NUMBER 2.17-07-4625	1 🔀 M 2 🗆 F	8. AGE (In yrs. last 76	birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER HOURS	24 HRS. MIN.	7. DATE OF (Month, I			Country	PLACE (State or Foreign
TOR	98. FACILITY NAME (If not inetitution, give Baltimore County RESIDENCE OF DECEDENT		ospital			nda1.			ATH			ltimo	
DIRECTOR	10a. STATE 10b. COUNT	timore			y, town o		ON						10d, INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	3303 Fairview Roa	ad				101.	2120					S.A.	HAT COUNTRY?
ВУ	11. MARITAL STATUS  1 Never Married 2 Married  3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 [ IF YES, GIVE WAI	YES 2X NO	NED O		WAS DECE If yes, spe- 1 TYES	city Cuber	n, Mexican	IC ORIGIN? ( s, Puerto Ric	Specify Yes an, etc.)	or No—	14. RACE Black Specif	- American Indian, White, etc.
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12) 11th Grade	UCATION le completed) College (1-4 or 5+)	(Giv.	e kind of a Do NOT us	usual or work done or retired.)	during mos	N t of working	g		ohn E			Co.
CO	17. FATHER'S NAME (First, Middle, Last) William J. Beck,	Sr.							et Sc				
TO BE	19a. INFORMANT'S NAME (Type/Print)	D1.					d Number	or Rural R	oute Number,	City or Town	, State, Zip		
۲	Mrs. Ruth Beck		20b. PLACE AI	_			_	ıe (	Caton				
	1 🕮 Buriel 2 🗆 Cremation 3 🗆 Rer 4 🗆 Donation 5 🗆 Other (Specify)	2004-20-500	cemetery, creat Lake	iew	ther place) Memo	oria.	l Pai	rk 4/	/8/93	Syke			
j	21. SIGNATURE OF FUNCTION SERVICE L	ICENSEE							Funera Road				
	26. PART   Enter the disease, or shock, or heart fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. DEC	ceused the dee e on each line.	SM	not enter	the mod	e of dyli	ng, such	es cardia	c or respir	atory arr	rest,	Approximata Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c	DR AS A CONSECU	JENCE O		L	CA	<i>i</i>	ET	oH,	ABU	ISE	
CE	PART II. Other significant condition	d	leath but not re	aulting	in the un	darlulan	201100 0	duan in E	net i I a	ta. WAS AN /		1	<u> </u>
MEDICAL	COPD, R	RONCE	HITIS				- Couse y			PERFORI	WED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL					26, PL/	VCE OF DE	EATH (Chec	ck only one)				
YSIC	EXAMINER? 1 YES 2 NO	HOSPITAL: 1   Inpatient 2					5 🗆 Res	sidence (	Other (S	Specify)			
ВУ РН	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF IN (Month, Day,	( Year)		M			NO		RIBE HOW IN			
ETED	3 Suicide 8 Could not be 4 Homicide determined	building, at	INJURY — At hom tc. (Specify)	ie, remi,	street, ract	ory, office				ON (Street ar Town, State)	nd Number	or Rural Ro	oute Number,
COMPLETED	29e. CERTIFIER (Check only one)  1 CERTIFYING PHYS 2 MEDICAL EXAMIN	SICIAN: To the best of m											end menner ee stated.
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIE	ris-ll					29c. LICE	NSE NUMI	133	3	29d. DAT	E SIGNED	(Month, Day, Year)
	30. NAME AND ADDRESS OF PERSON W	ICGH,	BAL	27) (Type	, Print)	lu	72	113	3.				
	31. DATE FILED (Month, Day, Year)  APR = 7 199	32. REGISTRAR	'S SIGNATURE	ndell									District to Day (/00

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician DIVISION OF VITAL RECORDS, P.O. BOX 68760,

ars 1, 2, 3 should

BALTIMORE, MARYLAND 21215-0020

107

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-by be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

I'M KNAL

BALTIMORE, MARYLAND 21215-0020

	Panes		
SICIAN: The law requires that the death certificate be executed within 🚁 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be defached for use as the burial-transit nermit. Pages	lygiene prior to burial, cremation, or removal.	r other traumatic event. the medical examinar must be notified at once.
rtificate be	ig physician	tiene prior t	ther traus
death ce	ne attendin	Aental Hyg	Ury. Or O
s that the	thed by th	alth and N	any Ini
w require	been sig	pt. of He	3 shows
W: The k	ificate has	State De	r item 2
PHYSICIA	this certi	with the	irked. oi
TENDING	DR: After	fter death	8 is ma
L OR AT	L DIRECT	? hours a	item 2
HOSPITA	FUNERAL	within 72	TANT: H
TO THE	TO THE	be filed	IMPOR

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF H	EALTH AND DEATH	MENTAL HYGIEN		3 09/93
	1. DECEDENT'S NAME (First, Middle, Last)	,	_			2. DATE OF DEATH		3. TIME OF DEATH
	Charles E. Benzel					MONTH 60	5 9	3 6:35 AM
	4. SOCIAL SECURITY NUMBER 218 039492		- /	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF SHITH (Month, Clay, Year)	1 0.	BIRTHPLACE (State or Foreign Country)
		1 M 2 D F	T YRS.	337	3313.	11/04	[2]	Md
œ	9a. FACILITY NAME (If not institution, give str	1			R LOCATION OF D	EATH	9c. COUNTY	OF DEATH
DIRECTOR	RESIDENCE OF DECEDENT	EN 1427611	NO	SPC	TMIRE			
REC	10a. STATE 10b. COUNTY	7.1	10c. CITY,	TOWN OR LOCAT	ION			10d. INSIDE CITY
		altimore						1 YES 2 NO
RAL	100. STREET AND NUMBER 426 Greenlow Roa	a		101.	ZIP CODE			OF WHAT COUNTRY?
BY FUNERAL	11. MARITAL STATUS				21228			ISA
F	1 Never Married 2 Nerried	12. WAS DECEDENT EVER IF FORCES? 12 YES	2 NO	If yes, spe	city Cuban, Mexica	NIC ORIGIN? (Specify Year, Puerto Rican, etc.)	or No- 14	. RACE — American Indian, Black, White, etc.
	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES	1 TYES	2 № NO Specif	y:		specify: white
COMPLETED	15. DECEDENT'S EDUC. (Specify only highest grade of	ATION ompleted)	16a. DECEDENT'S U	SUAL OCCUPATIO	N et of weeking	16b. KIND OF BU	SINESS/INDUS	
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	retired.)				
₩.		2	PBX	Install			P Tele	phone
ၓ	17. FATHER'S NAME (First, Middle, Last) Charles Benzel					ME (First, Middle, Meiden	,	
BE	19a. INFORMANT'S NAME (Type/Print)		10h MAII INO A	DDDESS /Street or		et Albrech Route Number, City or Tow		
2	Jeanne Benzel					salto, Md.	n, State, Zip Co 21228	
	20e. METHOD OF DISPOSITION	20b	PLACEANDDATEOF					or Town, State
	1 Burial 252 Cremation 3 Remon 4 Donation 5 Other (Specify)		etery, crematory or other reenMount	Cremate	orv		lto, M	
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE /		22. NAME AN	D ADDRESS OF FA	CILITY	ALC: THE	
	* Halles X	Hoch N	100550	Sterli	ng Ashto	n Funeral	Hame	
	23. PART I. Enter the diseases, or co	mplications that caused	the deeth. Do not	1/3h H'OT	mondson de of dying, auc	Avenue Ba	ratory arrest	Approximate
Į	ahock, or haart failure. Li IMMEDIATE CAUSE (Final	iat only one cause on e	ech line.					Interval Batween Onset and Death
	disease or condition resulting in death)	BROWN	STEM CU	IA				
					- 1			
NO N	Sequentially list conditions, b.		CONSEQUENCE OF:	C VISE	-ASF			
YA.	if any, leading to immediate cause. Enter UNDERLYING	20C 10 (01 A3 A	CONSECUENCE OF).					
Ē	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):					
CERTIFICATION	resulting in death) LAST d.							
	PART II. Other aignificant conditions	contributing to deeth be	ut not resulting in	the underlying	cause given in	Part i. 24a. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS
PHYSICIAN: MEDICAL						PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
						1 TYES 2	□ NO	OF DEATH?
ä								1 129 2 10
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	uoehizai .			ACE OF DEATH (Ch	eck only one)		
YSI	1 TES 2 NO	HOSPITAL:		OTHER:  Nursing Home	5 - Residence	8 Other (Specify)		
F	27. MANNED OF DEATH  1   Natural 5   Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME (		IRY AT	28d, DESCRIBE HOW II	NJURY OCCUR	ED
BY	2 Accident Investigation				ES 2 NO			
ED	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, term, stre ily)	et, factory, office		281. LOCATION (Street e City or Town, State)	nd Number or I	Rural Route Number,
9								
	290. CERTIFIER	AM. To the book of the			end piece, end due	to the cause(s) end man	ner ee stated.	
₹ I	(Check only	AN: To the best of my knowle				time date and place an	d due to the co	weeks) and manner or stated
COMPLETED	(Check only			in my opinion, de	ath occured at the			ouse(s) and manner as stated.
BE	(Check only one) 2 MEDICAL EXAMINER:		end/or investigation,	in my opinion, de				GNED (Month, Day, Year)
ш	(Check only 1 POEHTIFYING PHYSICI ONE) 2 MEDICAL EXAMINER:  29b. SIGNATURE AND TITLE OF CERTIFIER  VIRGIUD M. ATT  30. NAME AND ADDRESS OF PERSON WHO	On the basis of examination	and/or investigation,  And  The control of the cont	In my opinion, de	ath occured at the 29c, LICENSE NUM	BER	29d. DATE SI	
BE	(Check only 1 POEHTIFYING PHYSICI ONE) 2 MEDICAL EXAMINER:  29b. SIGNATURE AND TITLE OF CERTIFIER  VIRGIUD M. NO.	On the basis of examination	and/or investigation,  And  The control of the cont	In my opinion, de	ath occured at the 29c, LICENSE NUM		29d. DATE SI	
BE	(Check only 1 POEHTIFYING PHYSICI ONE) 2 MEDICAL EXAMINER:  29b. SIGNATURE AND TITLE OF CERTIFIER  VIRGIUD M. ATT  30. NAME AND ADDRESS OF PERSON WHO	On the basis of examination	and/or investigation,  And  The control of the cont	In my opinion, de	ath occured at the 29c, LICENSE NUM	BER	29d. DATE SI	

## TO THE HOSPITULOBE PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FLYERAL Manner of the confidence of the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours of the confidence of the confidence prior to burial, cremation, or removal. IMPORTANT. If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	1 - FOR STATE REGISTRAR	STATE OF MARYLAN	ND / DEPARTMENT OF CERTIFICATE O	HEALTH AND	MENTAL HYGII		20	097	94
	1. DECEDENT'S NAME (First, Middle, Last)	-1-17			2. DATE OF DEATH		3. TI	ME OF DEATH	
	Telitha (	TALITHAI	Brown		0.4 (	04 19	93 1	.251	м
	4. SOCIAL SECURITY NUMBER  210-00-7238  90. FACILITY NAME (If not institution, give	1 - M 2 X F	YRS. BUTTHE DAYS		7. DATE OF BIRTH (Month, Day Year)	52 1	BIRTHPLACE COUNTY)	(State or Foreig	n
DIRECTOR		co AveApt		imore		VE. COUNTY	Y OF DEATH		
REC	10e. STATE 10b. COUNT	TY	10c. CITY, TOWN OR LOC	ATION				INSIDE CITY	
	[//])		MAHIM	ORE_			-/	YES 2 NO	
FUNERAL	2504 W. PA	TAPSCO AVE	17/13-C	2123	D	10g. CITIZE	OF WHAT	COUNTRY?	
	11. MARITAL STATUS  1 Never Married 2 Married		2 NO If yes,	specify Cuben, Mexic	NIC ORIGIN? (Specify an, Puerto Rican, etc.)	Yee or No— 14	. RACE — An Black, White	nericen Indien, e, etc.	
B∀	3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DATE	1 🗆 Y	ES 2 NO Speci	ffy:		13/11	·K	- 1
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12)	UCATION 16 completed) College (1-4 or 5+)	Se. DECEDENT'S USUAL OCCUPA (Give kind of work done during in life. Do NOT use retired.)	TION most of working	16b. KIND OF E	BUSINESS/INDUS	TRY	7	
O.	17. FATHER'S NAME (First, Michiga, Last)			10 MOTHER'S N	AME (First, Middle, Maid				-
Ö	FRED MON	RE_		Mil	ADRED	Nann	5		
O BE	194. INFORMANT'S NAME (TypeProg)		196. MAILING ADDRESS (Single	and Number or Hurar	House Number City or I	Swert, Strate, Zip Co	ide)	<del></del> .	
٩	IONIA TOR	WA/	277 5.9	Pring	07.21	231			- 1
	20s METHOD OF DISPOSITION 1 Method 2 Cremestly 3 Plan	noval from State 20b. PL	ACE AND DATE OF DISPOSITION	Name of	DATE 20c.	OCATION - CITY	y or Yown, St	" 407	$\neg$
	21. SIGNATURE OF PURERAL SERVICE L		11/AN/LED	16/6RV	41043/	ANSO	WIE	MIN	2
	b L	N	22. G04)	VY7714	TON Tang	R4/1900	75 TA	7,	
	1 / NOVY / 1 /	lance	27	FRED	HILTON/	7999	21	229	
	23. PART I Enter the diseases, or shock, or heart failure.	complications that caused the List only one cause on each	ha death. Do not anter the ri h Ilna.	noda of dying, au	ch as cardiac or res	spiratory arrest		Approximata interval Between	een
	IMMEDIATE CAUSE (Final disease or condition	D						Onset and De	
	resulting in death)	DUE TO (OR AS A CO	seumonia						
-		DUE TO ON AS A CO	ONSEQUENCE OF):						
9	Sequantially list conditions, if any, leading to immediate	DUE TO (OR AS A CO	ONSEQUENCE OF):				<del>- i</del>		-1
8	cause. Enter UNDERLYING CAUSE (Disease or injury	c					ļ		- 1
	that initiated events resulting in death) LAST	DUE TO (OR AS A CO	ONSEQUENCE OF):						
CERTIFICATION	resoluting in deadily CAST	d							_
AL O	PART II. Other algolificant condition	na contributing to death but	not resulting in the underlyl	ng cause given in	Part I. 24s. WAS	AN AUTOPSY	24b. WERE	AUTOPSY FINDIN	IGS
<u>Ş</u>					PERF	ORMED?	COMP	ABLE PRIOR TO LETION OF CAUS	E
Ä I							OF OE	YES 2 NO	- 1
PHYSICIAN: MEDIC									
ᅙ	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	OTHER:	PLACE OF DEATH (C)	heck only one)				
IYS	1 X YES 2 □ NO  27. MANNER OF DEATH	1   Inpetient 2   ER/Outpetie	ent 3 DOA 4 Nursing Ho		6 Other (Specify)				
	1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	INJURY V	JURY AT /ORK?	28d. OEŞCRIBE HOV	V INJURY OCCUR	NED		
B	2 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF INJURY —	At home, farm, street, factory, off	YES 2 NO	201 LOCATION (C)		2 10 1		
COMPLETED	4 Homicide 6 Could not be determined	building, etc. (Specify)	Actions, fairle, actors, factory, or		City or Town, Sta	te)	Hurai Houte Ni	umber,	- 1
	290. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the beat of my knowledg	and death assumed that the state of						
ğ		ER: On the besie of sxaminetion er					euse(e) end n	nanner ee stated	.
	29b. SIGNATURE AND TITLE OF CERTIFIE			29c. LICENSE NU					
BE	llenni-	4 Chut	MO			<b>D</b>	IGNED (Month		1
2	30. NAME AND ADDRESS OF PERSON WI	10 COMPLETEO CAUSE OF DEATH	(ITEM 27) (Type, Print)	I O.C.M	Fi .	1 04	05 1	993	-
			111 Penn St	reet D	altimoro	M ¬ ~-	ا عمدا	212	0,1
	31. DATE FILEO (Month, Day, Year)	guia Davidson-han	T. ag.	LCCI. D	arrimore	- Mar	Land	212	
	ADD 07 1993	guna vavidon-1/m	10						

	1 - STATE REGISTRAR	STATE OF I	/ MARYLAND Ce		ICATE					GIENE			
	1. DECEDENT'S NAME (First, Middle, Li	E E.			BA		rnes		2. DATE OF DE			YEAR	3. TIME OF DEATH A
	4. SOCIAL SECURITY NUMBER 2/6-52-3800	5. SEX	6. AGE (In yrs. lest	birthday)	IF UNDER	DAYS	IF UNDER	24 HPIS. MIN.	7. DATE OF BIF	RTH (Year) 1	894	Count	
-	9a. FACILITY NAME (If not institution, g. St. Agnes Hospi		1160					ON OF DE	ATH	79		NTY OF D	yland DEATH
DIRECTOR	RESIDENCE OF DECEDENT				]	Balt:	imor	e Ci	ty				
l H	10a. STATE 10b. COL	JNTY		10c. CIT	Y, TOWN C	OR LOCATI	ION						10d, INSIDE CITY
	Maryland Bal	Ltimore		Ba	ltim	ore 1	High	land:	S				1 VES 2 NO
₹ Z	10e. STREET AND NUMBER					101.	ZIP CODE	E		T	10g. CITI	ZEN OF V	WHAT COUNTRY?
FUNERAL	2907 Florida Av							227	-			ted	States
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	TEVER IN U.S. ARI YES 2 NA WAR OR DATES	MED O		If yes, spe	cify Cube	OF HISPAN In, Maxicar Specify	IIC ORIGIN? (Spe n, Puerto Rican,	ecify Yea o atc.)	or No—	14. RACI Black Spec	E — American Indian, k, White, etc. #y: White
OMPLETED	15. DECEDENT'S (Specify only highest g	rade completed)	(Gh	ve kind of	USUAL Or work done	CCUPATIO during mos	N st of workin	ng	16b. KIND	OF BUSIN	NESS/INC	DUSTRY	
1	Elementary/Secondary (0-12)	College (1-4 or 5 -		emak	er				Own	Home	2		
E COM	17. FATHER'S NAME (First, Middle, Last)						16. MOTI	HER'S NAI	ME (First, Middle,				
₩ Б	George Kehne						Hal:	ie Fe	eete				
TO B	19a. INFORMANT'S NAME (Type/Print)								loute Number, City				
90	Grace E. Braswe	5TT						, Ba.	ltimore	_			
must be	1 N Burlal 2 Cremation 3 R 4 Donation 5 Other (Specify)	lemoval from State	206. PLACE A cornetery, crer MOUN	no date	ther place) LVE (	ition (Nar Cemet	me of terv	4/5		Fred			wn, siete Maryland
examiner	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE			22.	NAME AN	D ADDRES	SS OF FAC	CILITY				7 2 4 1 4
	Kirkley-Ruddick Funeral Home 421 Crain Hwy., S.E. Glen Burnie, MD 21061  23. PART I. Enter the diseases, or complications that caused the dasth. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate												
CERTIFICATION	shock, or heart failu iMMEDIATE CAUSE (Final disease or condition resulting in daath)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	a. DUE TO C.	(OR AS A CONSEC	UENCE O		tha moo	id 10	ing, auch	) my	per l	Control of the contro	est,	Approximate intervel Between Onset and Daath
AN: MEDICAL	PART II. Other significant conditions to the significant conditions of the significant condition	tay	death burnot re	sutting	in the un	of	74	2	F	WAS AN AL	ED?	24b	WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
SIC	EXAMINENT NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER	₹:			6 Other (Spec				
BY	27. MANNER OF DEATH  1 Destural 5 Pending 2 // Accident Investigation		ily, Year)		E OF URY M	28c. INJU WOF 1 V	JRY AT		26d, DESCRIBE	HOW INJ			
TED	3 Suicide 8 Could not determined	butiding.	F INJURY — At hon atc. (Specify)	ne, term, :	itreet, fact	ory, office			City or Town	(Street end n, State)	d Number	or Rural F	Route Number,
COMPLETED		IYSICIAN: To the best of											) and manner as stated.
O BE	296. SIGNATURE AND TITLE OF CERTIF	dul	m	a			D 3	Z (	924	2	29d. DAT	E SIGNED	3 93
-	30, NAME AND ADDRESS OF FERSON	WHO COMPLETED CAUS	SE OF DEATH (ITEM	27) (Type	20 55	Cat	on A	ve.	Baltin	more	. Ma	rv1=	and 21229
	31. DAJE FILED (Month, Day, Year)	32. REGISTRA	R'S SIGNATURE				J.1 1.		Daton	OIG	, 1.10	. <u> </u>	4114 61669
	APP 07 1993	Davidson	-gandell										

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	CERTIFICA	IE OF DEATH	REG. NO	D.					
	1. DECEDENT'S NAME (First, Middle, Last) WILLIAM L. BECK!	ER		2. DATE OF DEATH	2 93	3. TIME OF DEATH  6.00 P M				
	4. SOCIAL SECURITY NUMBER 220-14-9992 1 1 X M 2 - F 6	rs. last birthday) IF UN YRS. MONTH	DER 1 YEAR IF UNDER 24 HRS. IS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	Co	RTHPLACE (State or Foreign unity) Maryland				
	Se. FACILITY NAME (If not institution, give street and number)	9b. C	ITY, TOWN OR LOCATION OF D		9c. COUNTY O					
стоя	UNIVERSITY OF MARYLAND HESPIT	AL	BALTIMOR	LE	The second second					
H	10s. STATE 10b. COUNTY		N OR LOCATION			10d, INSIDE CITY LIMITS?				
N DI	MARYLAND  100. STREET AND NUMBER		KRIDGE TOTAL CODE		100 CITIZEN C	1 TYES 2 NO				
FUNERAL DIRECTOR	6809 MONT GOMERY R	D.,	212	-	U. S	i. A				
BY	1 Never Married 2 Merried 3 Widowed 4 Divorced FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	□ NO	13. WAS DECENDENT OF HISPA If yes, specify Cuben, Mexic 1 YES 2 WNO Speci	an, Puarto Rican, etc.)	В	ACE — American Indien, lack, White, etc. pecify: WH ITE				
TE	(Specify only highest grade completed)	a. DECEDENT'S USUAL (Give kind of work do. life. Do NOT use retire	ne during most of working	16b. KIND OF BU	JSINESS/INDUSTR	Υ -				
COMPLETED	Elementary/Secondary (0-12)  College (1-4 or 5 +)	Manf. Re		Self-	employed	1				
	17. FATHER'S NAME (First, Middle, Last)			AME (First, Middle, Maider	Sumeme)	•				
BE	Louis C. Becker	10h MAII INC ADDR		a May Harv	9	Y				
2	Elizabeth Becker		ess (Street and Number or Rural			21227				
ĺ	20s. METHOD OF DISPOSITION  1 Buriel 2 Cremetion 3 Removal from State cemeter.	ACE AND DATE OF DISP	OSITION /Name of	DATE 20c, L	OCATION — City or	Town, State				
	4 Donation 5 Opter (Specify) St.		theran Cem.		licott (	ity, Md.				
	21. SIGNATURE OF BUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  Gary L. Kaufman Funeral Homes  5695 Main St., Elkridge, Md. 21227									
	23. PART I. Enter the disease, or complications that caused the shock, or hear to livre. Liet only one cause on each	e deeth. Do not en	ter the mode of dying, suc	ch es cardiec or resp	piratory arrest,	Approximete interval Between				
	IMMEDIATE CAUSE (Final		HEMORRE			Onset and Death				
	DUE TO (OR AS A CO	NSEQUENCE OF):	THEMORRE	m62						
N	Sequentially list conditions, b. HYPERT	rension								
ÄŢ	If any, leading to immediate cause. Enter UNDERLYING	NSEOUENCE OF):								
CERTIFICATION	CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CO	NSEQUENCE OF):								
Ħ I	resulting in death) LAST									
	PART II. Other eignificent conditions contributing to deeth but n	not resulting in the	underlying cause given in	Pert i, 24a. WAS AI		246. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO				
EDICAL	INFECTION			1 _ YES		COMPLETION OF CAUSE OF DEATH?				
Σ				_		1 TYES 2 NO				
AN	25. WAS CASE REFERRED TO MEDICAL		28. PLACE OF DEATH (CI	neck only one)						
PHYSICIAN:	EXAMINER?  1 YES 2 NO  HOSPITAL:  1 Propertient 2 ER/Outpetter	m 3 DOA 4 N								
	27. MANNER OF DEATH  1 Natural 5 Pending  28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW	INJURY OCCURED					
BY	2 Accident Investigation	At home, farm, street, f	1 YES 2 NO	284 LOCATION (C)	and Montage of Do	(8 - 1)				
ETED	4 Homicide determined building, atc. (Specify)	trone, min, acces, i	actory, office	281. LOCATION (Street City or Town, State		ar Houte Number,				
COMPLET	29a. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of my knowledge one)  2 MEDICAL EXAMINER: On the basis of examination and					e(a) and manner as stated.				
BE	296. SIGNATURE AND TITLE OF CERTIFIER  WITH AND THE AN	Sm	29c. LICENSE NU	MBER	29d. DATE SIGN	ED (Month, Day, Year)				
5	JULIAN EDILS, MD UNIV. 01		OUD HOSPITE	I Bah	inoxo	min				
	APR 0 1993 July Davidson April	RE								
TI.	*** **									

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The Issue death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been in Harman and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dopt of Harman Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

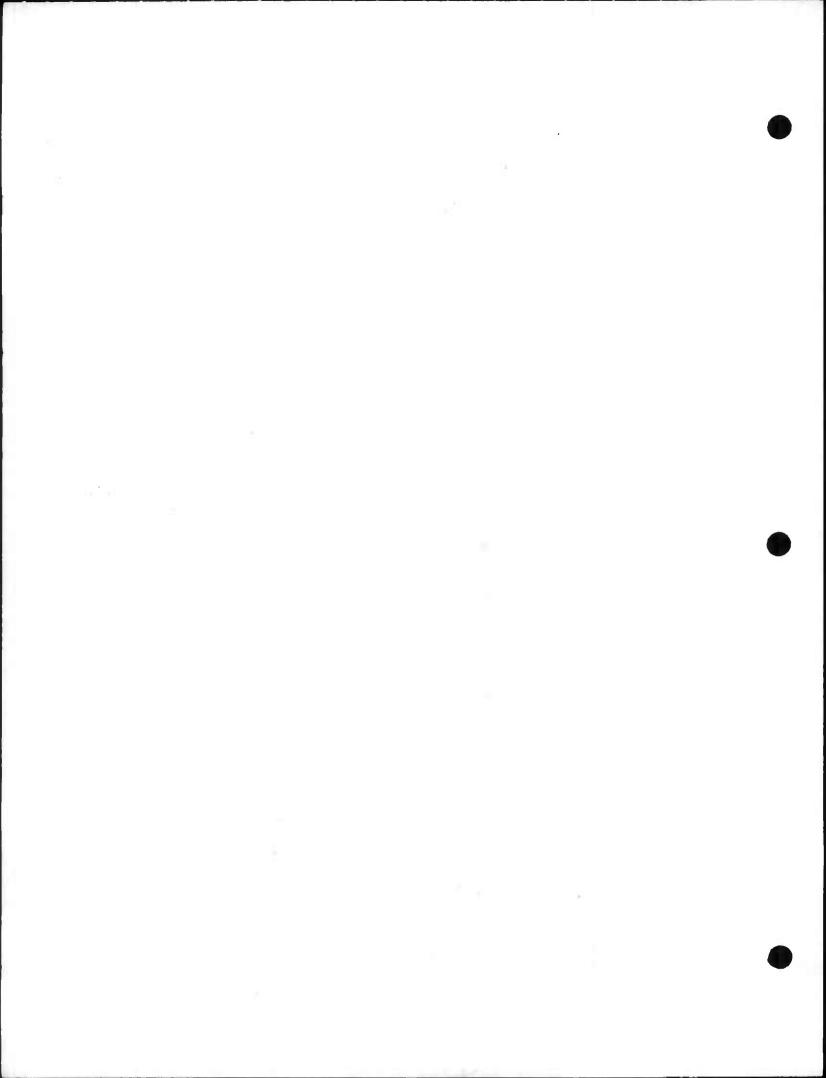
ps, P.O. BOX 68760,

DIVISION OF VITAL

The second second

BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as an included to mit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be rotained by the hospital or attending	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	REGISTRAR		CERTIF	ICATE OF	DEATH		REG. NO.	_			
1	1. DECEDENT'S NAME (First, Middle, Last) ROSE A .	RoBra	rutes	rd		2. DATE OF MONTH	DEATH DAY	9	35AR	3. TIME O	F DEATH M
	218780908	□ M 2 0 F 3	(In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, D	BIRTH Pay, Year)	7	Country	PLACE (Sit	MD .
TOR	96. FACILITY NAME (If not institution, give street  Univ. of Ma. +  RESIDENCE OF DECEDENT	end number) HOSDIta	R	96. CITY, TOWN	tmore			9c. COU	NTY OF DE	1-14-14-	
DIRECTOR	10a. STATE 10b. COUNTY  Md.		10c. CIT	Y, TOWN OR LOCA						10d. INSID	87
	100. STREET AND NUMBER 874 Carroll	C+			H. ZIP CODE			10g. CITI	ZEN OF W	HAT COUP	2 NO
FUNERAL	11. MARITAL STATUS 12.	. WAS DECEDENT EVER	N U.S. ARMED	13. WAS DE	21230 CENDENT OF HISPAN		Specify Yes	or No.— T	USA 14. BACE	- Americ	en Indien
ВУ	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES		It yes, s	pecify Cuban, Maxica 3 2 1 NO Specify	in, Puerto Rice	en, etc.)		Specif Afr	, White, et y:	rican
COMPLETED	15. DECEOENT'S EDUCATION (Specify only highest grade communication (Particularly (9-12))  Elementary/Secondary (9-12)	ON pleted) ollege (1-4 or 5+)	16a. DECEDENT'S (Give kind of life. Do NOT us	USUAL OCCUPATION or done during more retired.)	ON ost of working	16b. Ki	NO OF BUS	INESS/IND	USTRY	-	
BE CON	17. FATHER'S NAME (First, Middle, Last) Wesley	Brandford			18. MOTHER'S NA	ME (First, Mick Cather:		,	ndfo	rd	
10	19a. INFORMANT'S NAME (Type/Print) Hilda Jones				and Number or Rural I St. Balt			, State, Zip 230	Code)		
	20s. METHOD OF DISPOSITION		netery, cremetory or o			OATE		sdow	100	1.7	
	21. SIGNATURE OF FUNERAL SERVICE LICENS		tre	22. NAME A	no Address of FA step Brot 1300 Euta	hers l	Funer	al H	ome l	P.A.	
CERTIFICATION	23. PART I. Enter Me diseasea, or comphock, or heart feilure. Liet immediate CAUSE (Finel disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A	ach line.	1 m				atory arr	eat,	inte	roximata rval Between et and Death WIDS•
PHYSICIAN: MEDICAL CE	PART II. Other significent conditions co Hepathtis P Anemua of	+C.			g cause given in		e. WAS AN A PERFORM	AED?		AWAILABLE	ON OF CAUSE
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	QSPITAL:		28. P	LACE OF OEATH (Che	eck only one)					
HYSI		Inpatient 2 - ER/Outs 28a. DATE OF INJURY	28b. TIM	4 Nursing Hon	ne 5 🗆 Residence	6 Other (S)		ILIBY OCC	TIBEO		
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)		M 1	YES 2 NO				ONEO		
B	3 Suicide 6 Could not be 4 Homicide determined	28s. PLACE OF INJURY building, etc. (Spec	f — Al home, ferm, a cify)	treet, factory, offic	•	28f. LOCATIO	ON (Street an own, State)	nd Number	or Rural Ro	oute Numbe	v,
COMPLET	29a. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN EXAMINER: Or MEDICAL EXAMINER: Or									and mann	or an stated.
띪	296, SIGNATURE AND TITLE OF CERTIFIER	arel	.0		29c. LICENSE NUN					Month, Day	
2	30. NAME AND ADDRESS OF PERSON WHO SO HANNAH	CAUSE OF OE	ATH (ITEM 27) (Topo.	Print) Un	IV. Of	Md	· H	051	pita	0	
3	31. OATE FILED (Month, Day, Year)  ADD = 7 1002	32 REGISTRAR'S SIGN	ATURE								



BALTIMORE, MARYLAND 21215-0

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DIVISION OF VITAL RECORDS,	

296. SIGNATURE AND TITLE OF CERTIFIER

APR - 7 1993

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31. DATE FILED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

4000

32. REGISTRAR'S SIGNATURE

Julia Davidson-Randalle

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Bardin

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the houptain or amending the death certificate be executed within 24 hours after death.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burnal-transit permit. Pages 1 . 2 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is merked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

93 09798 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last)
HILDA 2. DATE OF DEATH 3. TIME OF DEATH **BARNES** 3/30793 YEAR 3:00\* 4 SOCIAL SECURITY MIMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE /State or Foreign 7/15/10 219-32-5803 82 1 M 2XXF MD 9a. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 720 BEAVERBROOK RD BALTIMORE DIRECTOR RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1- VES 2 NO BALTIMORE FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21212 U.S.A. 720 BEAVERBROOK ROAD 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 — YES 2 🕅 NO Specify: 14. RACE — American Indian, Black, White, stc. 1 Never Married 2 Married BY 3 🕅 Widowed 4 🗌 Divorced AFR. AMERICAN COMPLETED 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) (Specify only highest grade comp Elementary/Secondary (0-12) Coffege (1-4 or 5+) 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden S HENRIETTA SCOTT DANIEL DUNLAP notified at BE 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 6524 WATERLOO ROAD BALTO. MD 21227 WILLIAM BARNES 9 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State 1 Surial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) must must BALTO NATL CEM. 4/5/93 BALTO. MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTO. MD 21217 23. PART I, Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one ceuse on each line interval Between IMMEDIATE CAUSE (Finsi Onset and Death 9 disease or condition resulting in death) Parlura Longestine hen + 57 can1 DUE TO (OR AS A CONSEQUENCE OF): Syla, Mamie renal CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF) CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in desth) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AWAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 TYES 2 THO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:
4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) 1 TES 2 10 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28h TIME OF 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED INJURY 1 Natural 5 Pending 1 YES 2 NO В Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 🗌 Suicide 261. LOCATION (Street and Number or Rural Route Number City or Town, State) 6 Could not be 60 COMPLETED 28 4 Homicide 29a. CERTIFIER

Chart column 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, end due to the cause(a) and manner as stated.

29c. LICENSE NUMBER

Lourt

025655

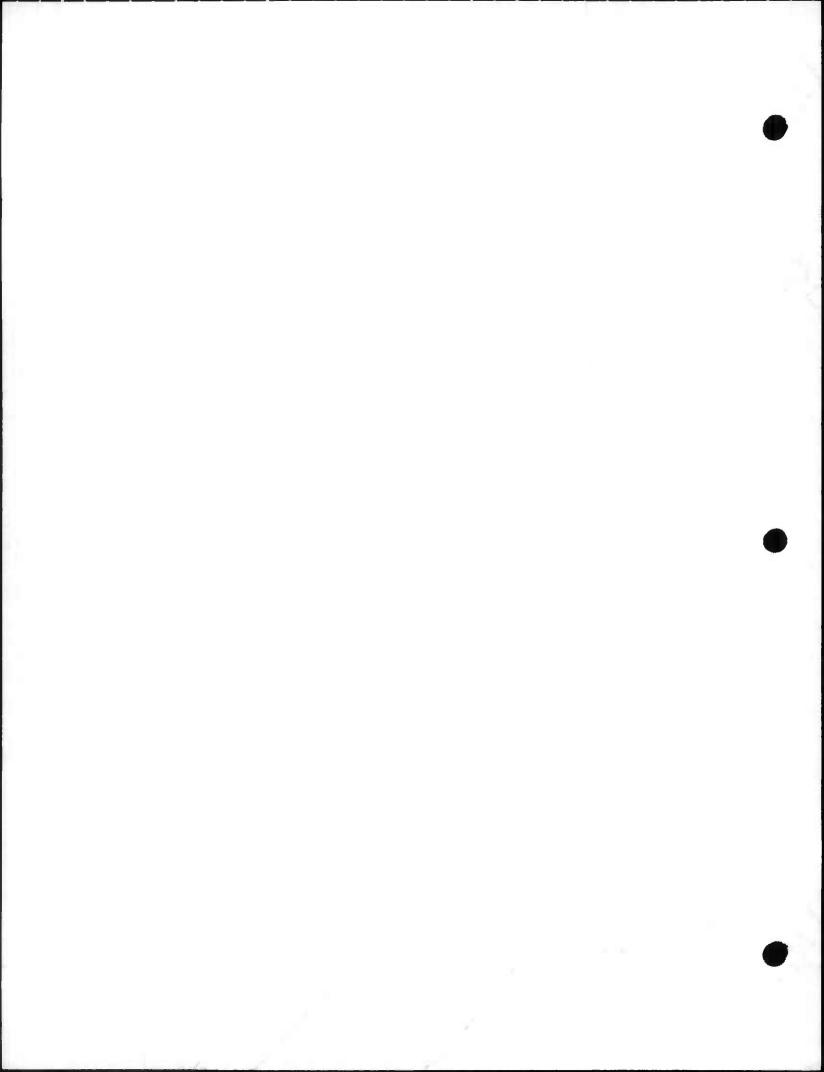
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MA

29d. DATE SIGNED (Month, Day, Year)

4-2-53

7-12-08



3. TIME OF DEATH

6-coyou

10d. INSIDE CITY

WHAT COUNTRY?

14. RACE — American Indian, Black, White, etc.

1 TYES XX NO

Approximate

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE

OF DEATH? 1 YES 2 NO

29d. DATE SIGNED (Month, Day,

intarval Between

Onset and Death

8. BIRTHPLACE (State or Foreign Country)

Carolina

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9c. COUNTY OF CEATH PRINCE

10g. CITIZEN OF

USA

1/17/44

REG. NO.

2. DATE OF DEATH

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1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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BURNS BARBARA 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. (Month, Day, Year) - 2 6 - 3 246-46-9062 1 | M 2 | R F ST YRS. use as the burial-transit permit. Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give 9b, CITY, TOWN OR LOCATION OF GEATH reater Laure DIRECTOR RESIDENCE OF DECEDEN 10c. CITY, TOWN OR LOCATION MD BUREC FUNERAL 10f. ZIP CODE BOWSPRIT 2070 24 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES X NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Maxican, Puerto Rican, atc.) BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married BΥ 1 YES 2 NO Specify: 3) Widowed 4 Divorced COMPLETED 16a. DECEOENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Floral Design for Elementary/Secondary (0-12) College (1-4 or 5+) detached 12 Flower Shop Owner once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname) page 5 should be F Woodrow W. Shoemaker Mildred Davis BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1118 Pemberton Ln. Lothian, Md. 20711 Robert Herndon å 20s. METHOD OF DISPOSITION
1\( \) Neuriel 2 \( \) Cremation 3 \( \) Removal from State
4 \( \) Donation 5 \( \) Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must director, Lincoln Cemetery 4/2/93 Brentwood, Maryland examiner 21. SIGNATURE OF FUNERAL MERVICE 22. NAME AND ADDRESS OF FACILITY the funeral Fort Lincoln Funeral Home, Inc. filled in by the fution, or removal. 3401 Bladensburg Rd. Brentwood, medical 23. PART i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final cremation. other traumatic event, the disease or condition CSADINE ARRHYDINIA
DUE TO (OR AS A CONSEQUENCE OF): has been signed by the attending physician and completely Dept. of Health and Mental Hyglene prior to burial, crematic executed within resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING e that the death certificate CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 injury. PART II. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL shows any Hypertension 1 | YES 2 | NO requires PHYSICIAN: 23 HT SICIAN: The law 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) item certificate h EXAMINER? HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA OTHER: 4 Nursing Home 5 Residence 8 Other (Specify) 6 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) COMPLETED 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide THE HOSPITAL OR AN THE FUNERAL DIRECT Red within 72 hours at 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, and due to the cause(e) end manner ee stated. TO THE FUNEFIAL O
TO THE FUNEFIAL D
So filed within 72 h
IMPORTANT: If its 2 MEDICAL EXAMINER: On the basis n, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. BE Examiner 2 4203 Queenssury Rd HyaTPUILE MD ZODE/

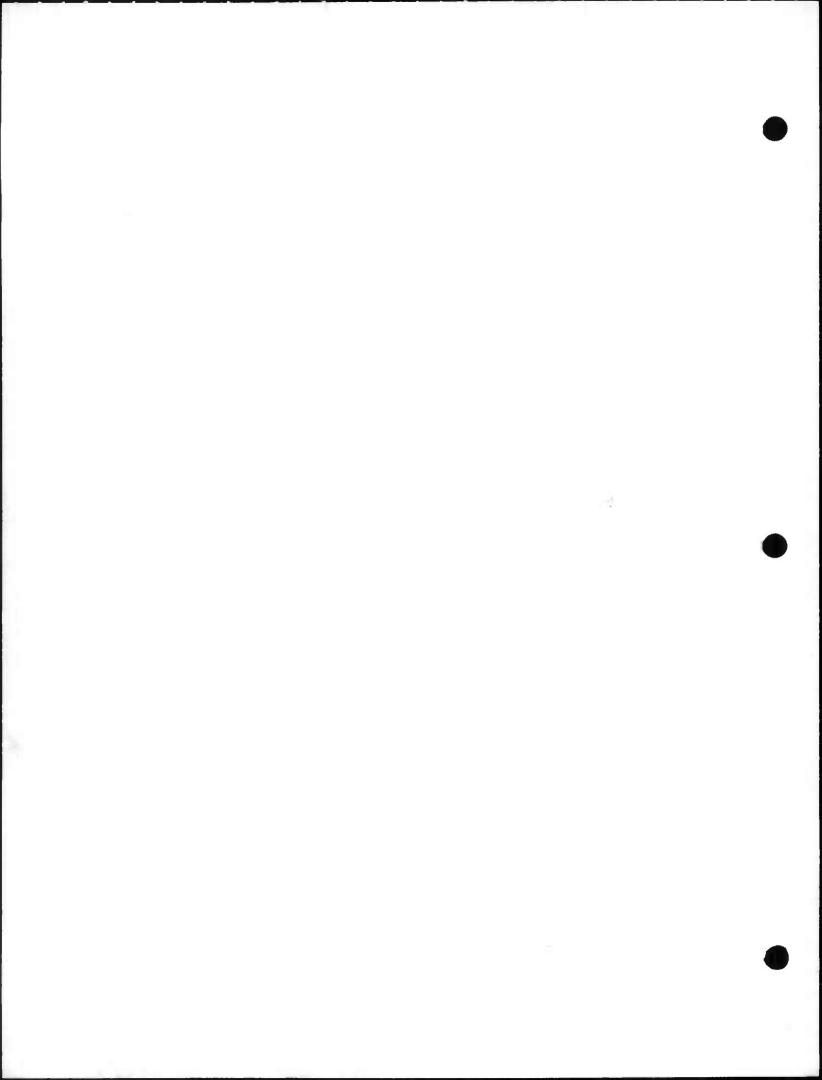
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

PIVISION OF VITAL RECORDS, P.O. BOX 68760,

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4	動	Ç.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF DEATH	REG. NO.

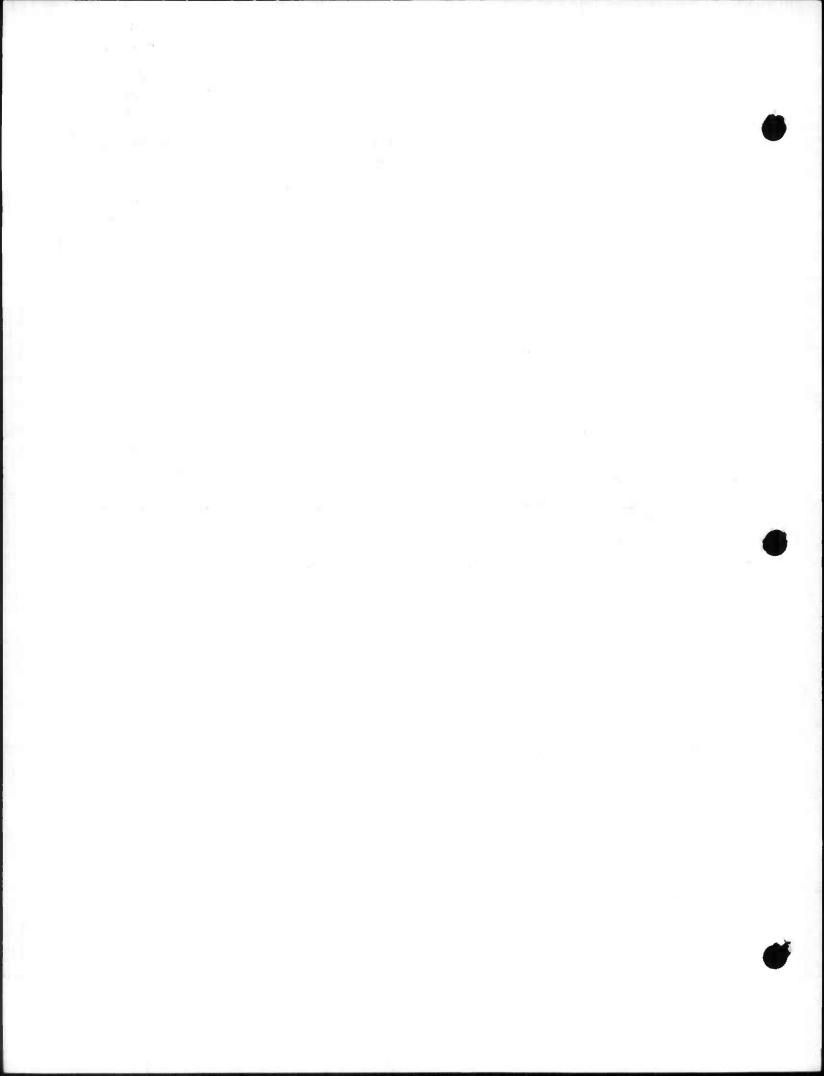
	1 - FOR STATE REGISTRAR		STATE OF MAR	YLAN	D / DEPAR	TMENT OF	HEALI F DE	H AND I	MENT	AL HYGIEN			0 2 0 0 0
	1. DECEDENT'S NAME (First, M								2. DAT	E OF DEATH	NY .	YEAR	3. TIME OF DEATH
	RUTH 4. SOCIAL SECURITY NUMBER		s sex 6. A	OF /h				III-EZAT	03	31	. 9	3	
	218-07-7280	,		BRADY  SEX  G. AGE (in yes, lest birthology)  SEX  G. AGE	Country	y)							
	9s. FACILITY NAME (If not instit	tution, give s		13		9b. CITY, TOV	N OR LOC	ATION OF DE		12/19			
TOR	NORTH ARUNDI	EL HO	SPITAL ASSO	CIA	TION	GLE	N BUR	RNIE			A	. A .	COUNTY
REC	10a. STATE 1	Ob. COUNTY										П	10d. INSIDE CITY
	Maryland A	Anne A	Arundle	_	Cr	ownsvil							1 TYES 2 NO
RA	General Hig	hwav				- 1							
N N	11. MARITAL STATUS	-					ECENDEN	T OF HISPAN				4. RACE	- American Indian,
	1 Never Married 2 Ma XX Widowed 4 Divorce					1 🗇	ES 2XX	iban, Maxica 10 Specify		Rican, atc.)			h:
		ENT'S EDUC		164	. DECEDENT'S	USUAL OCCUP	TION		16	b. KIND OF BUS	SINESS/INDU	STRY	WILLE
9	(Specify only his	College (1-4 or 6+)	+			most of wo	orking				a. BIRTHPLACE (State or Fore Country)  B. BIRTHPLACE (State or Fore Country)  Washington I  UNITY OF DEATH  A. A. COUNTY  10d. INSIDE CITY LIMITS? 1		
MP G	9th	to Local		]	Housew:	ife			_				
~ ~	17. FATHER'S NAME (First, Middle, Last)  Lester Bodmer										Sumame)		
8	19a, INFORMANT'S NAME (Type	/Print)			19b. MAILING	ADDRESS (Stre			_		n, State, Zip C	ode)	
	Marjorie C				2607	7th Av	e. H	yatts	vill	e, Md.	20785	5	44
Just	20a, METHOD OF DISPOSITION  X	3 🗆 Rame	ovel from State	cametan	v. crematory or o	ther place)							
	21. SIGNATURE OF PUBLICAL S		ENGLIF	Fo:	rt Line				4/5	/9B Br	entwoo	od,M	laryland
exami	1.56	1	May	26	1								
event, the	iMMEDIATE CAUSE (Finei disease or condition resulting in death)  Sequentielly list condition if sny, leading to immedia cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	ite	DUE TO (OR A	S A COI	MA NEOUENCE OF	ory tr	ut	mfre	to	~			Onset and Death
- 111	resulting in death) LAST	<u> </u>	J										
MEDIC	PART II. Other significant	/ -				n the underly	Ing ceus	e given in	Part i.	PERFOR	MED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
Item Si Ci A	25. WAS CASE REFERRED TO N EXAMINER?	MEOICAL	HOSPITAL:				PLACE OF	DEATH (Che	ck only o	one)			
5 ×	1 YES 2 NO			-		4 - Nursing I		Residence			LIMBY OCCU	200	
Z P	1 Natural 5 Per	nding estigation			INJ	URY	WORK?	. No	200. 00	SCHIBE HOW IF	SUNT OCCU	HEU	
	3 Suicide 6 Co	uld not be armined	28e. PLACE OF INJU- building, atc. (S	JRY — A Specify)	t home, term, s	street, tactory, o	fice		261. LO	CATION (Street a y or Town, State)	nd Number or	Runel R	oute Number,
MPLE													
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION  TO BE COMPLETED BY FUNERAL DIRECT  TO BE COMPLETED BY FUNERAL DIRECT  TO BE COMPLETED BY FUNERAL DIRECT  To Be Complete staminer must be notified at once.  TO BE COMPLETED BY FUNERAL DIRECT  TO BE COMPLETED B	29b. SIGNATURE AND TITLE OF									a and place, and			
IMPU	Mysel	One	2113	PHS	Y SICIAN						▶ 4		(Month, Day, Year)
	MAHESH S. OC	HANE	Y, M.D./757	5 R	ITCHIE		Y, S	E/GL	EN E	BURNIE,	MARYI	LANI	21061
	APR 07 1993		chi Davidson-A	anatur	EQ_						103110		



31. DATE FILED (Month, Day, Year)

32. REGISTRAR'S SIGNATURE

		1 - STATE REGISTRAR	STATE OF MARYLA			HEALTH AND	MENTAL	HYGIENI REG. NO.	E		
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE	OF DEATH	Y	EAR 3.	TIME OF DEATH
		Samuel Nathani		TH, Sr.	-		04	0	1 9	3 2	1487
P		217-07-5515	1 🔀 M 2 🗆 F	75 YRS.	IF UNDER 1 YEAR MONTHS DAY:		7. DATE 0 (Month) 3-1	Dey, Year)	100	BIRTHPLA Country) 1 ng 1	nia
2, 3 should	DIRECTOR	9a. FACILITY NAME (If not institution, give stre Franklin Square			Esse>	N OR LOCATION OF I	DEATH		Balti		
- Se		RESIDENCE OF DECEDENT  10a. STATE  10b. COUNTY		10c, CITY	TOWN OR LO	CATION				100	I. INSIDE CITY
permit. Pages		Maryland B	altimore	Es	ssex	10f. ZIP CODE			40- CITIZEN	1 [	LIMITS?  YES 2 NO COUNTRY?
- <del>1</del>	FUNERAL	706 B Pine Br				2	1221			USA	COUNTRY
21215-0020 al or attending physician. for use as the burial-transit	B	11. MARITAL STATUS  1 Never Married 2 Married  3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 ☐ YES IF YES, GIVE WAR OR DA	2 V NO	If yes,	DECENDENT OF HISPA apacity Cuban, Mexic (ES 2 X) NO Spec	an, Puerto R		or No.— 14.	RACE — i Black, WI Specify:	American Indian, hite, etc. White
	ETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)	ompleted)	16a, DECEDENT'S L (Give kind of w life. Do NOT use	ork done durina	ATION most of working	186.	KIND OF BUS	INESS/INDUS	TRY	
YLAND 2.  by the hospital of the detached for	COMPL	6th Grade  17. FATHER'S NAME (First, Middle, Lest)	College (1-4 or 5+)	Retire	ed Secu	urity Gua			reen (	Co.	
YLA d by the	101 PM	Mr. James Ed	ward Booth			Fanni	e S	need	Booth		
BALTIMORE, MARYLAND or death. Page 6 may be retained by the hospits the funeral director, page 5 should be detached val.	5	1991. INFORMANT'S NAME (Typo/Print)  Mrs. Gene A. Boot	h			et end Number or Aura Branch P				212	21
ALTIMORE, I leath. Page 6 may be funeral director, page	must be	20a, METHOD OF DISPOSITION  1   Display   Command   Comm	al from State 20b.i	PLACE AND DATE O	F DISPOSITION	(Neme of tery 4/5	/Q3		timore		sume iryland
BALTIMO after death. Page 6 y the funeral directs noval.		21. SIGNATURE OF PUNERAL SERVICE LICE			22. NAME	AND ADDRESS OF FULL OF	ACILITY				Tyrana
	medical examiner	15-11		_	237	E. Patap	sco A	ve., B	alto.	, MD.	21225
24 hours r filled in b	event, the medic	22. PART I. Enter the diseases, or constant, or heart failure. Li IMMEDIATE CAUSE (Final disease or condition resulting in death)	Respiratory  Due to (or As A	ch line.		mode of dylng, su	ch as card	lac or respir	atory arrest		Approximate Interval Between Onset and Death
P.O. BOX 68760, ith certificate be executed within fending physician and completely in Hyglene prior to burial. creman	or other traumatic	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A C			denocarci	noma				
ADS, if the dea by the atl	AL C	PART II. Other significant conditional	e cancer		the underly	ring cause given in	Part I.	24a. WAS AN A PERFORI	MED?	AMA	RE AUTOPSY FINDINGS ILABLE PRIOR TO MPLETION OF CAUSE DEATH?
AL RECOS he law requires tha has been signed is Dept. of Health a	shows any	Chronic obstructive Corpalmonale	e pulmonary	disease			_		^	10	YES 2 NO
<b>⊢</b> F ≘ ≋	PHYSICIAN:		HOSPITAL:		26. OTHER:	PLACE OF DEATH (C	heck only one	)			
F VI	14S	1 YES 2 NO	Inpatient 2 ER/Outpat 28e. DATE OF INJURY		4 🗌 Nursing H	ome 5 Residence	-				
ON OF DING PHYSIC After this ce death with th	marked, BY Pt	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU	M 1	WORK? YES 2 NO	28d. DE\$	CRIBE HOW IN	JURY OCCUR	ED	
DIVISION OF VITOR OF VITOR OF ALTENDING PHYSICIAN: DIRECTOR: After this certifications after death with the St	28 Is TED	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY - building, etc. (Specif	— At home, farm, st	reet, factory, of	ffice	281. LOCA City o	TION (Street er or Town, Stete)	nd Number or i	Rurel Route	Number,
DI PITAL OR PRAL DIRI	MP I		AN: To the best of my knowle On the basis of examination								manner en stated
THE HOSPITAL THE FUNERAL filed within 72		296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE N					nth, Day, Year)
THE OT THE De filed	TO BE	Bauta J.  30. NAME AND ADDRESS OF PERSON WHO	Partier	PO.	Oring	1440	37		104	1	193
		Dr. Bonita Portier	9000 Frank	lin Squa	are Dr.	. Baltimo	re, Ma	arylan	d 2123	37	

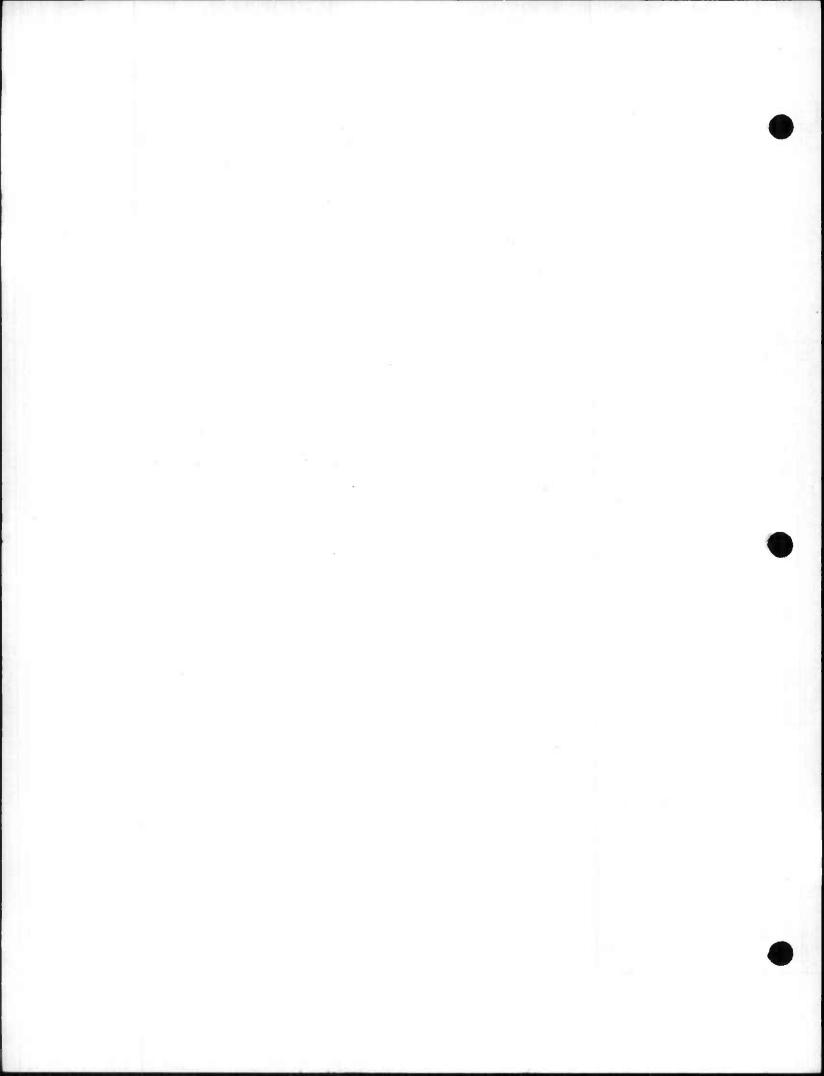


TO THE HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an event teath. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DHECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE UP	MARYLAND /		ICATE				MENIA	REG. NO.	E		
	1. DECEDENT'S NAME (First, M	in Dy Er	, Et	hE	/	9.	,		2. DATE MONT	OF DEATH	9	3 2	TIME OF DEATH  3 500 M
	4. SOCIAL SECURITY NUMBER 2219-05-797		6. AGE (In yrs. las	t birthday)	IF UNDER	DAYS	IF UNDER	24 MRS. MIN.	7. DATE (Mont)	OF BIRTH	00	Country)	yland
	9e. FACILITY NAME (If not instit		34	1110.	9b. CITY	TOWN O	R LOCATIO	ON OF DE		-05-10	9c. COUNT		
OR	Frederick H	Mealth Care C	enter		Frederick							eder	
C	RESIDENCE OF DECE	DENT		T 10c CI7	Y, TOWN O	DR LOCAT	ION					I 10	d. INSIDE CITY
DIRECTOR	Maryland	Howard Cour	itv		Lisbo								LIMITS?
1	10e. STREET AND NUMBER	noward cour	i.c.y		JI DAG	-	ZIP CODE				10g. CITIZE		T COUNTRY?
ER/	15944 Fred	lerick Road					217	765			U	.S.A	
BY FUNERAL	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorce	ENT EVER IN U.S. AR 1 TYES 2 XI WAR OR DATES											
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ᇤ	(Specify only in Elementary/Secondary (0-12	ighest grade completed)  College (1-4 or	H4m	ive kind of Do NOT u	work done ( se retired.)	during mos	st of workir	g					
OMPL	7				Home	emake	er				Domes	tic	
8	17. FATHER'S NAME (First, Midd									Middle, Maiden			
BH	Martin Lt	ther Grimm				V/2:				Gosnel.			
2		C. Bidinger								ninste:			7
11.3	20s. METHOD OF DISPOSITION	4	20b. PLACE	OF DISPO					vesu		CATION — CH		
	1 X Burlei 2 Cremation 4 Donetion 5 Other (S		Mor		Chape	el Ce	emete	erv		W	oodbir	e. M	D
	21. SIGNATURE OF FUNERAL S	Λ			22.	NAME AN	D ADDRE	S OF FA					
	> Brian	n X. Na	ight							OME (P. 1784 (*			,
	23. PART i. Enter the disc shock, or hee	reses, or complications to	had caused the de	eth. Do	not enter	the mo	de of dy	ing, auc	h aa cen	diac or reapi	ratory arres	it,	Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Due to (or As a consequence of):								Onset and Death				
ATION	Sequentially list condition if any, leading to immedic cause. Enter UNDERLYIN	ete	O (OR AS A CONSE	OUENCE O	PF):								
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in deeth) LAST	€ c.	TO (OR AS A CONSE	OUENCE C	HF):								
DICAL	PART II. Other significant	conditions contributing	to death but not i	reaulting	in the un	nderlying	g cause :	jiven in	Part I.	24a. WAS AN PERFOR 1 YES 2	MED?	AM CC	ERE AUTOPSY FINDINGS ARLABLE PRIOR TO OMPLETION OF CAUSE DEATH?
ME												1	YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO	MEDICAL				26. Pt	ACE OF C	EATH /Ch	eck only o	ne)			
SICI	EXAMINER?	HOSPITAL:	☐ ER/Outpatient 3	DOA	OTHER	R:				er (Specify)			
Н	27. MANNER OF DEATN	28e. DATE	OF INJURY	28b. TII	AE OF	28c. INJ	URY AT	raidenica		SCRIBE HOW I	NJURY OCCU	RED	
ВУ Р	1 Natural 8 Pe	nding restigation	, Day, Year)	lin.	JURY M		RK? /ES 2 [	] NO					
ETED B	3 Suicide 8 Co	28e. PLACE	OF INJURY At hog, etc. (Specify)	ome, farm,	street, fact	tory, offic				CATION (Street or Town, State)	and Number or	Rural Rout	e Number,
COMPLE	CONSON ONLY	YING PNYSICIAN: To the best											nd manner ee stated.
ш	296. SIGNATURE MIN TITLE O	есентин					29c, LIC	ENSE NUI			29d. DATE	SIGNEO (M	onth, Day, Year)
TO B	KI	un					6	120	- 49	79	1	-6.	- 93
F		MILLER		M 27) (Typ	e, Print)			×1717					
	APR 6 199	ar) 32. BEGIST	RAR'S SIGNATURE										



ge 6 may be retained by frector, page 5 should be r must be notified at	
SPITAL WITH HANG PHYSICIAN: The law requires that the death certificate be executed within executs after death. Page 6 may be retained by the hospital or attending physician.  WERAL PHECHAL After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should him 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  WE if them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

TO BE CO!

29b. SIGNATURE

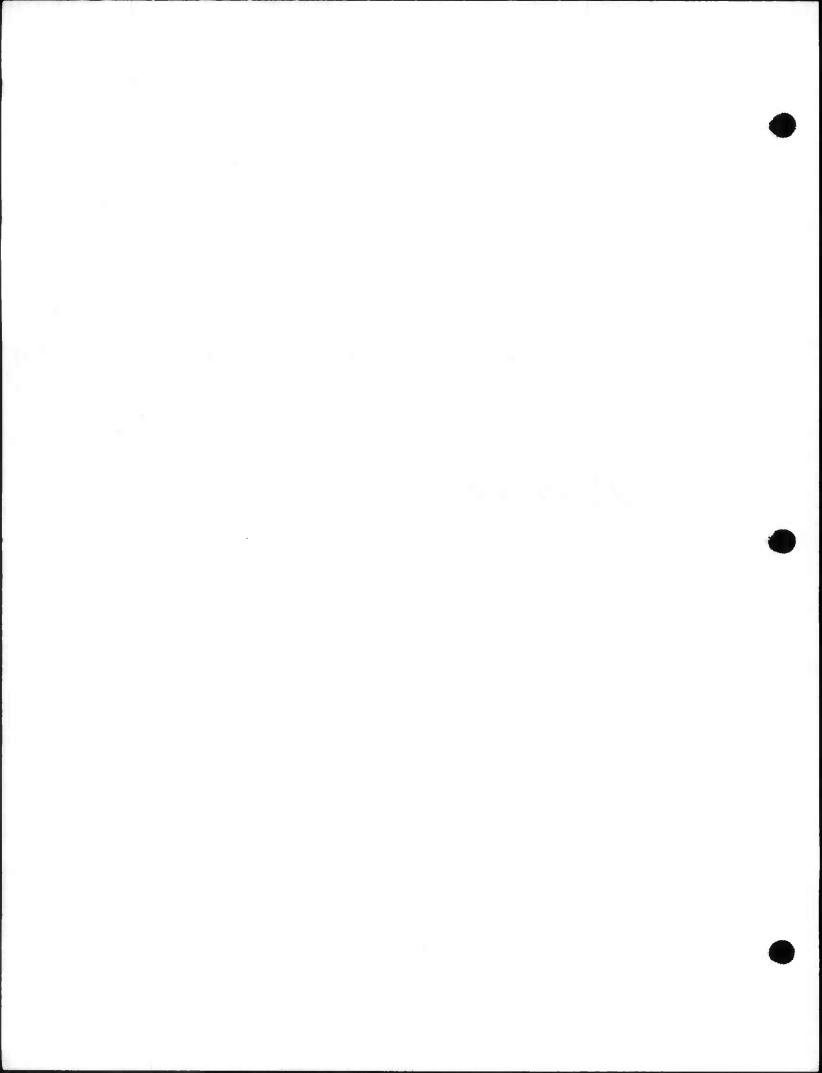
	FOR 1 - STATE REGISTRAR	STATE OF MARYL	LAND / DEPARTI CERTIFIC			MENTAL HYGIENI REG. NO.	E	93 09803
	1. DECEDENT'S NAME (First, Middle, Last) Grace Adalene	Bloedorn		,,,,,		2. DATE OF DEATH DA April 1	1 9 9	
	4. SOCIAL SECURITY NUMBER 314-18-6809	5. SEX 6. AGE	, , , , , , , , , , , , , , , , , , , ,	F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 4/30/18	Co	RTHPLACE (State or Foreign ountry) MD
OR OR	90. FACILITY NAME (If not institution, give so Maryland Mason RESIDENCE OF DECEDENT		.9		eysvill		Balt	imore
FUNERAL DIRECTOR	10e. STATE 10b. COUNT	ı 1timore		rown or Locat		- <u>-</u>		10d. INSIDE CITY LIMITS? 1 YES 2 X NO
HAL	100. STREET AND NUMBER 2516 Joppa Terra	ace		101	21234		772	DE WHAT COUNTRY?
≱	2516 Joppa Terrace  11. MARITAL STATUS  1  Never Merried 2  Merried 3  Midowed 4  Divorced  12. WAS DECEDENT EVER IN U.S. ABMED FORCES? 1 YES 2 MNO IF YES, GIVE WAR OR DATES  13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— lif yes, specify Cuben, Mexican, Puerto Rican, etc.)  14. RACE — Black, Will yes, specify: Union of the property of t							
COMPLETED	15. OECEDENT'S EOL (Specify only highest grade Elementary/Secondery (0-12)		16e. DECEDENT'S US (Give kind of wor iiie. Do NOT use of Practica	k done during mo etired.)	st of working	166. KIND OF BUS		White w ch Home Hospi
100	17. FATHER'S NAME (First, Middle, Last)  Jacob C. Wils	son			Mary	F . McMul	lan	
	196. INFORMANT'S NAME (Type/Print)  196. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Mrs. Ora Breeden  4404 Sweet Air Road Baldwin, MD. 2							
	20e, METHOD OF DISPOSITION 1 Suriel 2 Cremetion 3 Rem 4 Donetion 6 Other (Specify)	loval from State	other place of disposit Woodlawn	Cemeter	y 4	1-5 Woo	ation — city of dlawn,	
	21. SIGNATURE OF FUNERAL SERVICE U	LA		Ruc		n Funera		e, Inc. MD 21204
	23. PART I. Enter the dieseses, or shock, or heert failure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)	a.						Approximate Interval Between Onset and Death
	Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	c	A CONSEQUENCE OF):					
	PART II. Other significant condition	na contributing to deeth		the underlyin	g csuse given in	Part I. 24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2  NO
I SICIAN.	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 VES 2 NO  27. MANNER OF DEATH	HOSPITAL: 1   Inpatient 2   ER/Ou 26a. OATE OF INJURY	rtpatient 3 DOA 4	THER:	LACE OF OEATH (Ch	eck only one)  6  Other (Specify)  28d, DESCRIBE HOW I	NJURY OCCURE	0
10 01	1 Netural 6 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day, Year)	RY — At home, ferm, str	M 1 🗆	PRK? YES 2 NO	261. LOCATION (Street and City or Town, State)	and Number or R	
APLETE	20a CERTIFIER	SICIAN: To the best of my kno	wiedur, death ocurred	at the time, date	and place, and due	to the ceuse(s) end me	nner as stated.	

Sweet Air Road

Phoenix, MD

Paul M. Rivas,
31. DATÉ FILEO (Morth, Day, Year)
APR 06 1993 М.Д. 3421 32. HEMSTHAR'S SIGNATURE

VHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)



		FOR
1	_	STATE
	_	REGISTRAR

TO BE COMPLETED BY FUNERAL DIRECTOR

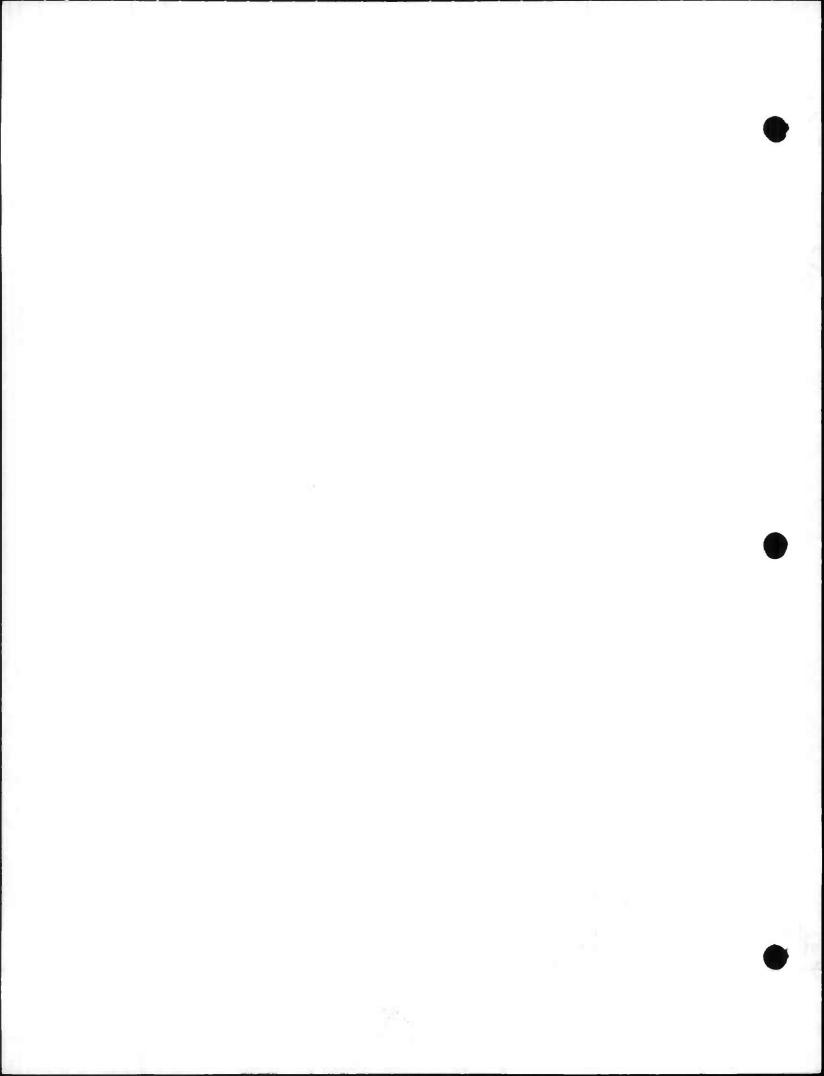
CERTIFICATE OF DEATH  CERCINETY MAN PITTLE AND ADDRESS  LUTHER  CRAWFORD  LUTHER  CRAWFORD  1. ADDRESS AND ADDRESS	1 - STATE REGISTRAR	STATE OF MARYL					MENTAL HYGIEN REG. NO.	E			
LUTTER CRAFFORD  SOLUTION MARIEN  SEX B. A.B. (E. pr. 1 and binding)  1 SEX B. A.B. (E. pr. 1 and binding)			OLITTI	IOAIL	OI DE	X1111	2. DATE OF DEATH			. TIME OF DEATH	
250-54-7105   Ref 2   F 57   Yes   Control of Management o	LUTHER	CRAWFORD					MONTH - 30	- 5	253	м	
BE A PACIFY MANE (I not inclined, you a street and manes)  LITERITY MEDICAL CENTER  BALTTIMORE CITY  MD.  BALTTIMORE CITY  MD.  BALTTIMORE  BALTTIMORE  STATE  BALTTIMORE  STATE  BALTTIMORE  STATE SAVE  BALTTIMORE  STATE SAVE  BALTTIMORE  STATE SAVE  SAVE SAVE  SAVE SAVE  SAVE SAVE  SAVE SAVE  SAVE SAVE  SAVE SAVE  SAVE SAVE  SAVE SAVE  SAVE			(In yrs. last birthday)			-	7. DATE OF BIRTH		B. BIRTHPL	ACE (State or Foreign	
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## Moderned 4   Drocceles   F YES, GIVE WAN OR DATES   1   TES 2   MO    ## DECEMBER SHOULTRING   1   MARK (Proc 1)   MARK (Pr	The second secon	12. WAS DECEOENT EVER IF	N U.S. ARMED	13.	WAS DECENDENT	OF HISPAN	IIC ORIGIN? (Specify Yes	or No-	14. RACE	- American Indian	
Sequentiary   Security   Sequence   Sequentiary   Sequence   Sequence   Sequentiary   Sequence   Sequence   Sequentiary   Sequence   Se		IF YES, GIVE WAR OR D	ATES								
Content on the plant rando compland;   College (14 or 5 :)   Col	- 21	CATION								ACK	
TO, MATIERTS NAME (First, Models, Latel)  LUTHER BENJAMIN CRAWFORD  18. MOTHERTS NAME (First, Models, Machine Control Surremain)  ALITHA HAMILTON  190. MALING ADDRESS (Stored and Number of Rural About Manthew Copy of Rural, State, 2D Cody)  EUGENE CRAWFORD  25.13 LINDEN AVE BALTO, MD 2,1217  28. METHOD OF DISPOSITION  RE bertial 2 (Ceremetters 1) II Removed from States  10 Demoralis 2 (Demoralis 2) ID Demoral 10 (Demoral from States)  120. MALING ADDRESS (Stored and Number of Rural About Manthew Copy of Rural, State, 2D Cody)  25.13 LINDEN AVE BALTO, MD 2,1217  28. METHOD OF DISPOSITION  RE bertial 2 (Demoralis 2) ID Demoral 1 (Demoral from States)  121. MALE AND ADDRESS OF FACILITY  JOSEPH L. RUSS FUNERAL HOME  22.22 W. NORTH AVE BALTO, MD. 21216  23. MARE AND ADDRESS OF FACILITY  JOSEPH L. RUSS FUNERAL HOME  22.22 W. NORTH AVE BALTO, MD. 21216  24. MARE AND ADDRESS OF FACILITY  JOSEPH L. RUSS FUNERAL HOME  22.22 W. NORTH AVE BALTO, MD. 21216  25. MARE AND ADDRESS OF FACILITY  JOSEPH L. RUSS FUNERAL HOME  26. LOCATION AND ADDRESS OF FACILITY  JOSEPH L. RUSS FUNERAL HOME  27. MALINE AND ADDRESS OF FACILITY  JOSEPH L. RUSS FUNERAL HOME  28. MARE AND ADDRESS OF FACILITY  JOSEPH L. RUSS FUNERAL HOME  29. MARE AND ADDRESS OF FACILITY  JOSEPH L. RUSS FUNERAL HOME  20. LOCATION AND ADDRESS OF FACILITY  JOSEPH L. RUSS FUNERAL HOME  20. LOCATION AND ADDRESS OF FACILITY  JOSEPH L. RUSS FUNERAL HOME  ADDRESS OF FACILITY  JOSEPH L. RUSS FUNERAL HOME  20. LOCATION AND ADDRESS OF FACILITY  JOSEPH L. RUSS FUNERAL HOME  ADDRESS OF FACILITY  JOSEPH L. RUSS FUNERAL HOME  ADDRESS OF FACILITY  JOSEPH L. RUSS FUNERAL HOME  ADDRESS OF FACILITY  JOSEPH L. RUSS FUNERAL HOME  ADDRESS OF FACILITY  JOSEPH L. RUSS FUNERAL HOME  ADDRESS OF FACILITY  JOSEPH L. RUSS FUNERAL HOME  ADDRESS OF FACILITY  JOSEPH L. RUSS FUNERAL HOME  ADDRESS OF FACILITY  JOSEPH L. RUSS FUNERAL HOME  ADDRESS OF FACILITY  JOSEPH L. RUSS FUNERAL HOME  ADDRESS OF FACILITY  JOSEPH L. RUSS FUNERAL HOME  ADDRESS OF FACILITY  JOSEPH L. RUSS FUNERAL FUNERAL HOME  ADDRESS	(Specify only highest grade	completed)	(Give kind of	work done	during most of wo	rking	16b. KIND OF BUS	SINESS/IND	USTRY	3	
THE BENJAMIN CRAWFORD  100. MALITHA HAMILTON  110. MARING ADDRESS (Since and Maribor or Name). Tape Code)  251.3 LINDEN AVE BALTO, or Som, Since, Type Code)  251.3 LINDEN AVE BALTO, or Som, Since, Type Code)  251.3 LINDEN AVE BALTO, or Som, Since, Type Code)  251.3 LINDEN AVE BALTO, or Som, Since, Type Code)  251.3 LINDEN AVE BALTO, Or Som, Since, Type Code)  251.3 LINDEN AVE BALTO, CO., MD.  21. SINGHITH (Code)  25. MARING ADDRESS (Since and Maribor or Name)  25. MARING ADDRESS (Code)  25. MARING ADDRESS (Code)  25. MARING ADDRESS (Code)  27. SINGHITH (Code)  27. SINGHITH (Code)  27. SINGHITH (Code)  28. MARING ADDRESS (Code)  28. MARING ADDRESS (Code)  29. MARING ADDRESS (Code)  29. MARING ADDRESS (Code)  29. MARING ADDRESS (Code)  20. MARING ADDRESS (Code)  20. MARING ADDRESS (Code)  20. MARING ADDRESS (Code)  20. MARING ADDRESS (Code)  20. MARING ADDRESS (Code)  20. MARING ADDRESS (Code)  20. MARING ADDRESS (Code)  20. MARING ADDRESS (Code)  20. MARING ADDRESS (Code)  20. MARING ADDRESS (Code)  20. MARING ADDRESS (Code)  21. MARING ADDRESS (Code)  22. MARING ADDRESS (Code)  23. MARING ADDRESS (Code)  24. MARING ADDRESS (Code)  25. MARING ADDRESS (Code)  26. MARING ADDRESS (Code)  27. MARING ADDRESS (Code)  28. MARING ADDRESS (Code)  29. MARING ADDRESS (Code)  20. MARING ADDRESS (Code)  20. MARING ADDRESS (Code)  20. MARING ADDRESS (Code)  20. MARING ADDRESS (Code)  20. MARING ADDRESS (Code)  20. MARING ADDRESS (Code)  20. MARING ADDRESS (Code)  20. MARING ADDRESS (Code)  20. MARING ADDRESS (Code)  20. MARING ADDRESS (Code)  20. MARING ADDRESS (Code)  21. MARING ADDRESS (Code)  22. MARING ADDRESS (Code)  23. MARING ADDRESS (Code)  24. MARING ADDRESS (Code)  25. MARING ADDRESS (Code)  26. MARING ADDRESS (Code)  27. MARING ADDRESS (Code)  27. MARING ADDRESS (Code)  28. MARING ADDRESS (Code)  29. MARING ADDRESS (Code)  20. MARING ADDRESS (Code)  20. MARING ADDRESS (Code)  20. MARING ADDRESS (Code)  20. MARING ADDRESS (Code)  20. MARING ADDRESS (Code)  20. MARING ADDRESS (Code)  20. MARING ADDRESS (Code)  20. MA	Elementary/Secondary (0-12)	College (1-4 or 5+)	100		MAN		WAT	rerfi	RONT		
LUTHER BENJAMIN CRAWFORD  198. MALITHA HAMILTON  199. MEMORIANT'S NAME (propring)  2513 LINDEN AVE BALTO, or Som, Som, Som, Condition, Som, Som, Condition, Som, Som, Condition, Som, Som, Condition, Som, Som, Condition, Som, Som, Condition, Som, Som, Condition, Som, Som, Condition, Som, Som, Condition, Som, Som, Condition, Som, Som, Condition, Som, Som, Condition, Som, Som, Condition, Som, Som, Condition, Som, Som, Condition, Som, Som, Som, Som, Condition, Som, Som, Som, Som, Som, Som, Som, Som	17. FATHER'S NAME (First, Middle, Last)					THER'S NA	ME (First, Middle, Melden	Surname)	-		
2513 LINDEN AVE BALTO, MD 2,217  280. BETHOO OF DISPOSITION   Surviva   Correction of Disposition   Control of Dispositio	LUTHER BENJAM	IN CRAWFORI	D								
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, internal between onesting in death.  23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, internal between onesting in death.  24. PART II. Control of the conditions of the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, internal between onesting in death.  25. Sequentially list conditions.  26. DUE TO (OR AS A CONSEQUENCE OF).  27. WAS CAUSE (Please or injury that inflated events resulting in death but not resulting in the underlying cause given in Part I.  26. DUE TO (OR AS A CONSEQUENCE OF).  27. WAS CAUSE (Please or injury that inflated events resulting in conditions contributing to death but not resulting in the underlying cause given in Part I.  26. DUE TO (OR AS A CONSEQUENCE OF).  27. WAS CAUSE (Please or injury that inflated events resulting in the underlying cause given in Part II.  26. DUE TO (OR AS A CONSEQUENCE OF).  27. WAS CAUSE (Please or injury that inflated events resulting in the underlying cause given in Part II.  26. DUE TO (OR AS A CONSEQUENCE OF).  27. WAS CAUSE (Please or injury that inflated events resulting in the underlying cause given in Part II.  26. DUE TO (OR AS A CONSEQUENCE OF).  27. WAS CAUSE (Please or injury that inflated events resulting in the underlying cause given in Part II.  26. DUE TO (OR AS A CONSEQUENCE OF).  27. WAS CAUSE (Please or injury that injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury injury.  28. DUE TO (OR AS A CONSEQUENCE OF).  29. DUE TO (OR AS A CONSEQUENCE OF).  29. DUE TO (OR AS A CONSEQUENCE OF).  29. DUE TO (OR AS A CONSEQUENCE O			19b. MAILING								
Busting   Committee   Commit	EUGENE CRAWFO	RD	2513	LI	NDEN A	VE	BALTO, N	4D	2,121	7	
21. Septimating for Funeral Setting Countries and Constituting to death but not resulting in the underlying cause given in Part I.  22. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24. WAS CASE REFERRED TO MEDICAL EXAMINER:  1   VES 2   NO  25. MARE AND ADDRESS OF PERSON WHO COMPLETED CANSE (Record in My knowledge, death occurred at the time, data and piace, and due to the cause(s) and manner as stated.  26. DAME INDER EXTENDED TO THE SIGNATURE OF PERSON WHO COMPLETE COUNTS (RECORD) AND COMPLETE COUNTS (RECORD) AND COMPLETE COUNTS (RECORD) AND COUNTS (RECORD) A	20a. METHOD OF DISPOSITION	comi from State	PLACE AND DATE	PLACE AND DATE OF DISPOSITION (Name of				CATION —	City or Town	n, Stata	
JOSEPH L. RUSS FUNERAL HOME 2222 W. NORTH AVE BALTO, MD. 21216 22. PART LETHE the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final diseases or condition resulting in death)  BUE TO (AN AS A CONSCOURNCE OF)  A DUE TO (AN AS A CONSCOURNCE OF)  BUE TO (AN AS A CONSCOURNCE OF)  CAUSE (Final Disease)  DUE TO (AN AS A CONSCOURNCE OF)  DUE TO (AN AS A CONSCOURNCE OF)  CAUSE (TOTAL DISEASE)  DUE TO (AN AS A CONSCOURNCE OF)  DUE TO (AN AS A CONSCOURNCE OF)  CAUSE (TOTAL DISEASE)  DUE TO (AN AS A CONSCOURNCE OF)  CAUSE (TOTAL DISEASE)  DUE TO (AN AS A CONSCOURNCE OF)  CAUSE (TOTAL DISEASE)  DUE TO (AN AS A CONSCOURNCE OF)  CAUSE (TOTAL DISEASE)  DUE TO (AN AS A CONSCOURNCE OF)  CAUSE (TOTAL DISEASE)  DUE TO (AN AS A CONSCOURNCE OF)  CAUSE (TOTAL DISEASE)  DUE TO (AN AS A CONSCOURNCE OF)  CAUSE (TOTAL DISEASE)  DUE TO (AN AS A CONSCOURNCE OF)  CAUSE (TOTAL DISEASE)  DUE TO (AN AS A CONSCOURNCE OF)  CAUSE (TOTAL DISEASE)  DUE TO (AN AS A CONSCOURNCE OF)  CAUSE (TOTAL DISEASE)  DUE TO (AN AS A CONSCOURNCE OF)  CAUSE (TOTAL DISEASE)  DUE TO (AN AS A CONSCOURNCE OF)  CAUSE (TOTAL DISEASE)  DUE TO (AN AS A CONSCOURNCE OF)  CAUSE (TOTAL DISEASE)  DUE TO (AN AS A CONSCOURNCE OF)  CAUSE (TOTAL DISEASE)  DUE TO (AN AS A CONSCOURNCE OF)  CAUSE (TOTAL DISEASE)  DUE TO (AN AS A CONSCOURNCE OF)  CAUSE (TOTAL DISEASE)  DUE TO (AN AS A CONSCOURNCE OF)  CAUSE (TOTAL DISEASE)  DUE TO (ON AS A CONSCOURNCE OF)  CAUSE (TOTAL DISEASE)  DUE TO (ON AS A CONSCOURNCE OF)  CAUSE (TOTAL DISEASE)  DUE TO (ON AS A CONSCOURNCE OF)  CAUSE (TOTAL DISEASE)  CAUSE (TOTAL DISEASE)  DUE TO (ON AS A CONSCOURNCE OF)  CAUSE (TOTAL DISEASE)  DUE TO (ON AS A CONSCOURNCE OF)  CAUSE (TOTAL DISEASE)  DUE TO (ON AS A CONSCOURNCE OF)  CAUSE (TOTAL DISEASE)  DUE TO (ON AS A CONSCOURNCE OF)  CAUSE (TOTAL DISEASE)  DUE TO (ON AS A CONSCOURNCE OF)  CAUSE (TOTAL DISEASE)  DUE TO (ON AS A CONSCOURNCE OF)  CAUSE (TOTAL DI	4 Donation 5 Other (Specify)		WESTERN	STA	AR		BAI	OT.	CO.	, MD.	
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MANERO FO DEATH    Notice   September	23. PART I. Enter the diseases, Dr o	complications that caused	d the death. Do								
Sequentially list conditions   Sequentially list conditions (If any, leading to immediate cause. Enter NUMERILYING CAUSE (Disease or injury that initiated vertice resulting in death) LAST   SCIENT		List only one cause on e	ach line.								
Sequentially list conditions, if any, leading to immediate cause, Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24. WAS ANAUTOPSY PERFORMED?  1 YES 2 NO  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  26. PLACE OF DEATH (Check only one)  27. MANHER OF DEATH  1 Natural 5 Pending Schedert (Month, Day, War)  28. DATE OF INJURY AND HOME SCHEDER (Month, Day, War)  29. CERTIFIER  29. CERTIFIER  29. LICENSE NUMBER  2	disease or condition		194009	121	21 1	n (8	retion				
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CAUSE (Disease or Injury that intifiated events resulting in death) LAST  DUE TO (OR AS A CONSCOURCE OF):  DUE TO (OR AS AN AUTOPSY FINDINGS ANALABLE FINCH TO ONLY OR TO CONSCOURCE OF DEATH (ITEM 27) (TYPE, Print)  DUE TO (OR AS AN AUTOPSY FINDINGS AND AUTOPSY FIN	Sequentially list conditions	· Artes	191 50	10	0528	YSS	iculer ohs	e95	se		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMAGO?  1 YES 2 NO  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  26. PLACE OF DEATH (Check only one)  27. MANNER OF DEATH  1 Normal 5 Pending Investigation  28a. DATE OF INJURY  28b. TIME OF INJURY AT OWNERS INJURY AT OWNERS AND INJURY OCCURED (Check only one)  28a. DATE OF INJURY — At home, farm, street, factory, offlice  28b. PLACE OF INJURY — At home, farm, street, factory, offlice  28c. CERTIFIER (Check only one)  28c. CERTIFIER (Check only one)  28c. DATE OF INJURY — At home, farm, street, factory, offlice  28c. CERTIFIER (Check only one)  28c. PLACE OF INJURY — At home, farm, street, factory, offlice  28c. DATE OF INJURY OF INJURY OCCURED (Chy or lown, State)  28c. PLACE OF INJURY — At home, farm, street, factory, offlice  28c. DATE OF INJURY OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY — At home, farm, street, factory, offlice  28c. CERTIFIER (Check only one)  28c. DATE OF INJURY — At home, farm, street, factory, offlice  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy	if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE O	F):	2 0	-					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMAGO?  1 YES 2 NO  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  26. PLACE OF DEATH (Check only one)  27. MANNER OF DEATH  1 Normal 5 Pending Investigation  28a. DATE OF INJURY  28b. TIME OF INJURY AT OWNERS INJURY AT OWNERS AND INJURY OCCURED (Check only one)  28a. DATE OF INJURY — At home, farm, street, factory, offlice  28b. PLACE OF INJURY — At home, farm, street, factory, offlice  28c. CERTIFIER (Check only one)  28c. CERTIFIER (Check only one)  28c. DATE OF INJURY — At home, farm, street, factory, offlice  28c. CERTIFIER (Check only one)  28c. PLACE OF INJURY — At home, farm, street, factory, offlice  28c. DATE OF INJURY OF INJURY OCCURED (Chy or lown, State)  28c. PLACE OF INJURY — At home, farm, street, factory, offlice  28c. DATE OF INJURY OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY — At home, farm, street, factory, offlice  28c. CERTIFIER (Check only one)  28c. DATE OF INJURY — At home, farm, street, factory, offlice  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy or lown, State)  28c. DATE OF INJURY OCCURED (Chy	CAUSE (Disease or Injury	DIETO OR AS A CONSEQUENCE OF							-		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. Was an Autopsy Perrometry 1		DUE TO (CHA AS A CONSEQUENCE OF):						i 1			
25. WAS CASE REFERRED TO MEDICAL  EXAMINER?  1   YES 2   NO  26. PLACE OF DEATH (Check only one)  27. MANNER OF DEATH  1   Netural 5   Pending Investigation  3   Suicide 8   Could not be determined    4   Could not be determined    28. PLACE OF INJURY — At home, farm, street, factory, office    29. CERTIFIER (Check only one)  29. CERTIFIER (Check only one)  29. CERTIFIER (Check only one)  29. CERTIFIER (Month, Dey, Year)  29. CERTIFIER (Check only one)  29. CERTIFIER (Check only one)  29. CERTIFIER (Month, Dey, Year)  29. CERTIFIER (Check only one)  29. CERTIFIER (Che								ENT			
25. WAS CASE REFERRED TO MEDICAL  EXAMINERY 1 YES 2 NO  26. PLACE OF DEATH (Check only one)  27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify)  28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 3 Suicide 8 Could not be defermined defermined 28. PLACE OF INJURY AT Non-Street and Number or Rural Route Number, City or Town, State)  298. CERTIFIER (Check only 0 PHYSICIAN: To the best of my knowledge, desth occurred at the time, data and place, and due to the cause(s) and manner as stated.  298. SIGNATUBE AND TITLE OF CERTIFIER  296. DATE SIGNED (Month, Day, Year)  297. LICENSE NUMBER 298. SIGNATUBE AND TITLE OF CERTIFIER 298. SIGNATUBE AND TITLE OF CERTIFIER 299. LICENSE NUMBER 290. DATE SIGNED (Month, Day, Year)  290. DATE SIGNED (Month, Day, Year)  291. SIGNATUBE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  290. DATE SIGNED (Month, Day, Year)  291. SIGNATUBE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  292. LICENSE NUMBER 293. DATE SIGNED (Month, Day, Year)  294. DATE SIGNED (Month, Day, Year)  295. THE SIGNED (Month, Day, Year)  296. DATE SIGNED (Month, Day, Year)  297. THE SIGNED (Month, Day, Year)  298. DEATH 1 MONTH DATE SIGNED (Month, Day, Year)  299. DATE SIGNED (Month, Day, Year)  290. DATE SIGNED (Month, Day, Year)  290. DATE SIGNED (Month, Day, Year)  290. DATE SIGNED (Month, Day, Year)  290. DATE SIGNED (Month, Day, Year)						given in	Part I. 24s. WAS AN. PERFOR				
25. WAS CASE REFERRED TO MEDICAL  EXAMINER?  1	C31 d10-	primons	my C	in	est.				C	OMPLETION OF CAUSE	
## HOSPITAL: 1   YES 2   NO   1   Inpetient 2   CEROutpetient 3   DOA   4   Nursing Home 5   Residence 8   Other (Specify)    27. Manner of Death   28e. Date of Injury   28b. Time of North   28c. Injury at Work?   1   YES 2   NO   28c. Injury at Work?   1   YES 2   NO   28c. PLACE OF INJURY — At home, farm, street, factory, office   28l. LOCATION (Street and Number or Rural Route Number, City or Town, State)    29e. CERTIFIER (Check only orle)   2   MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.  29b. SIGNATURE AND TITLE OF CERTIFIER   29c. LICENSE NUMBER   29d. DATE SIGNED (Month, Day, Year)   4   4   4   4   4   4   4   4   4										The second secon	
## HOSPITAL: 1   YES 2   NO   1   Inpetient 2   CEROutpetient 3   DOA   4   Nursing Home 5   Residence 8   Other (Specify)    27. Manner of Death   28e. Date of Injury   28b. Time of North   28c. Injury at Work?   1   YES 2   NO   28c. Injury at Work?   1   YES 2   NO   28c. PLACE OF INJURY — At home, farm, street, factory, office   28l. LOCATION (Street and Number or Rural Route Number, City or Town, State)    29e. CERTIFIER (Check only orle)   2   MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.  29b. SIGNATURE AND TITLE OF CERTIFIER   29c. LICENSE NUMBER   29d. DATE SIGNED (Month, Day, Year)   4   4   4   4   4   4   4   4   4											
1   YES 2   NO	EXAMINER?			OTHE		DEATH (Ch	ack only one)				
Natural   S   Pending   Investigation   S   Could not be determined   26s. PLACE OF INJURY — At home, farm, street, factory, office   28s. LOCATION (Street and Number or Rural Route Number, City or Town, State)   26s. PLACE OF INJURY — At home, farm, street, factory, office   28s. LOCATION (Street and Number or Rural Route Number, City or Town, State)   26s. PLACE OF INJURY — At home, farm, street, factory, office   28s. LOCATION (Street and Number or Rural Route Number, City or Town, State)   26s. PLACE OF INJURY — At home, farm, street, factory, office   28s. LOCATION (Street and Number or Rural Route Number, City or Town, State)   26s. PLACE OF INJURY — At home, farm, street, factory, office   28s. LOCATION (Street and Number or Rural Route Number, City or Town, State)   26s. PLACE OF INJURY — At home, farm, street, factory, office   28s. LOCATION (Street and Number or Rural Route Number, City or Town, State)   26s. PLACE OF INJURY — At home, farm, street, factory, office   28s. LOCATION (Street and Number or Rural Route Number, City or Town, State)   26s. PLACE OF INJURY — At home, farm, street, factory, office   28s. LOCATION (Street and Number or Rural Route Number, City or Town, State)   26s. PLACE OF INJURY — At home, farm, street, factory, office   28s. LOCATION (Street and Number or Rural Route Number, City or Town, State)   26s. PLACE OF INJURY — At home, farm, street, factory, office   28s. LOCATION (Street and Number or Rural Route Number, City or Town, State)   26s. PLACE OF INJURY — At home, farm, street, factory, office   28s. LOCATION (Street and Number or Rural Route Number, City or Town, State)   26s. PLACE OF INJURY — At home, farm, street, factory, office   28s. PLACE OF INJURY — At home, farm, street, factory, office   28s. PLACE OF INJURY — At home, farm, street, factory, office   28s. PLACE OF INJURY — At home, farm, street, factory, office   28s. PLACE OF INJURY — At home, farm, street, factory, office   28s. PLACE OF INJURY — At home, farm, street, factory, office   28s. PLACE OF INJ		1 Inpetient 2 ER/Outp		4 🗆 Nun	sing Home 5 🗆	Rasidence	(-,-,-,-,-				
29s. CERTIFIER (Check only one) 29s. SIGNATURE AND TITLE OF CERTIFIER  29b. SIGNATURE AND ADDRESS OF PERSON WHQ COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  1					WORK?		28d. DEŞCRIBE HOW II	NJURY OCC	CURED		
29s. CERTIFIER (Check only orle)  29s. SERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.  29s. SIGNATUBE AND TITLE OF CERTIFIER  29c. LICENSE NUMBER  29d. DATE SIGNED (Month, Day, Year)  30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  7. HO RPENGILMO 2600 LIVERTH HOLDS AND 21215	2 Accident Investigation	28. DI ACE OE IN 111701									
(Check only 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.  29b. SIGNATUBE AND TITLE OF CERTIFIER  29c. LICENSE NUMBER  29d. DATE SIGNED (Month, Day, Year)  46193  30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  1. OR PENGILLEY 2600 LIVETH HOLDS AVE BRIT', MO 21215'	- Codia not be	building, etc. (Spec	<ol> <li>PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)</li> </ol>				281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
(Check only 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.  20 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.  29b. SIGNATUBE AND TITLE OF CERTIFIER  29c. LICENSE NUMBER  29d. DATE SIGNED (Month, Day, Year)  46193  30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  1. WILL OF PENGIN MY 2600 LIBERTY HOLDS AVE BRIT', MO 21215'	29e. CERTIFIER		terral superiors		CENTRAL C		9.77				
296. SIGNATUBE AND TITLE OF CERTIFIER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. DATE SIGNED (Month, Day, Year)  46/93  30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  T. Uhlo RPEH911100 2600 LILENTHER HETTS AVE B911, mo 21215.	(Check only										
Theraing Physius D30115 \$46193  30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  T. Uhlo RPehalimo 2600 Liberty Herrs Are Balt, mo 21215.				, ні іту о							
T. Uhlo Kpehailmo 2600 LIBERTY HERS AVE BAH, mo 21215.	( 5.)	-	ing p	2431		30	IBER	29d. DATE	SIGNED (N	Aonth, Day, Year)	
31. DATE FILED (Month, Day, Year)  APR = 7 1993  ALL: Neida D	30. NAME AND ADDRESS OF PERSON WH	7 4 6				Herr	's Ave B	न्नान प	mo	21215	
MPK = (1993 Gille Teride De la	31. DATE FILED (Month, Day, Year)							/			
- COO Manuscription of the Cooperation of the Coope	APK - / 1993	Fishe Deviden-A	andath								

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit perm be filed within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

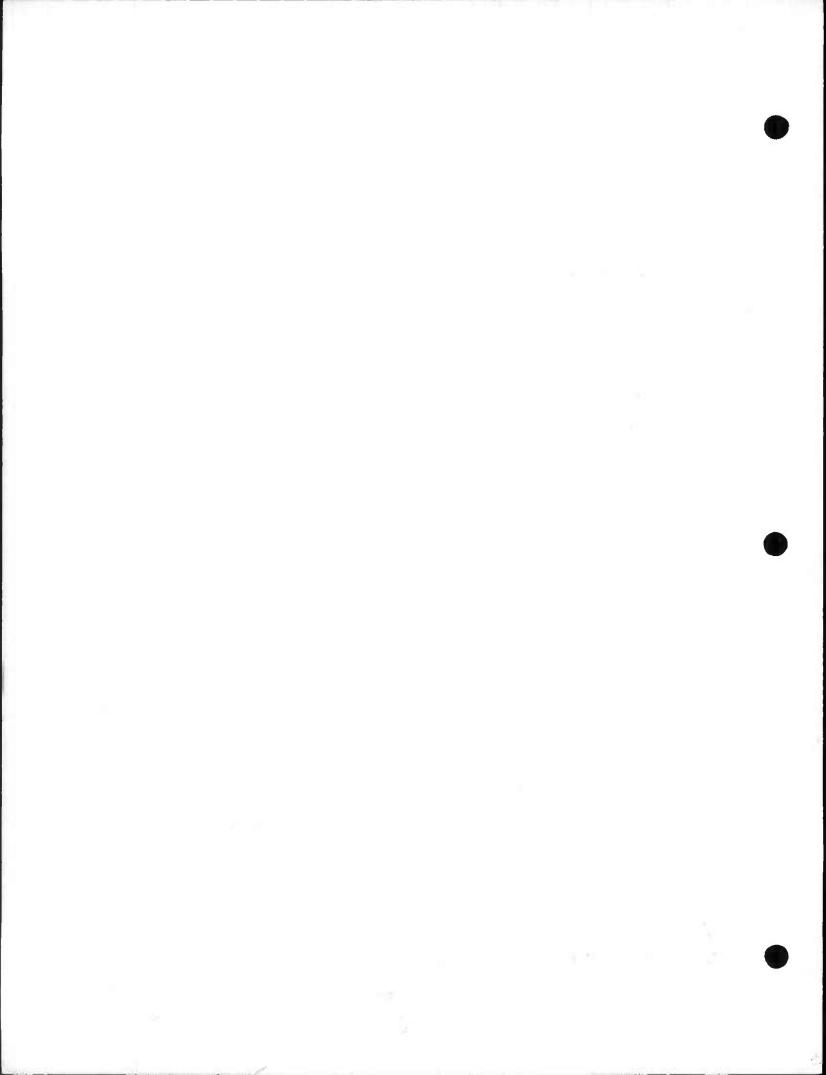
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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		1 - FOR STATE REGISTRAR	STATE OF MARYLA	AND / DEPAR CERTIF	TMENT OF H	HEALTH AND	MENTAL HYGIEN		7 0	0300
s 1. 2, 3 should		1. DECEDENT'S NAME (First, Middle, Last) OS Car	Robert	Chri	stmas		2. DATE OF DEATH DAY YEAR 4 5 93		3. T	IME OF DEATH
	E COMPLETED BY FUNERAL DIRECTOR	4. SOCIAL SECURITY NUMBER 213-32-8674	1 □ M 2 □ F 91	n yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		902	Mary	E (State or Foreign
			e. FACILITY NAME (If not institution, give street end number)  034 01d Frederick Rd.				Baltimore Baltim			
permit. Pages			imore	10c. CIT	Y, TOWN OR LOCAT	TION				INSIDE CITY LIMITS? YES 2 NO
SION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020 IENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit fire death with the State Dept. of health and Mental Hyglene prior to burial, cremation, or removal.  8 is marked, or litem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.		6034 Old Freder				21228			S.A.	COUNTRY?
		11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	If yes, sp	ecity Cuban, Mexica 2 NO Specifi	NIC ORIGIN? (Specify Ye in, Puerlo Rican, etc.) y:	a or No — 14.	Specify:B	
		15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)		18a. DECEDENT'S (Give kind of v He. Do NOT us Minist		ON sst of working	16b. KIND OF BU	SINESS/INDUS	TRY	
		17. FATHER'S NAME (First, Middle, Last) Oscar James Chris				IAME (First, Middle, Meiden Sumame)  Gertrude White				
	TO BE	19a INFORMANT'S NAME /Resolved						vn, Stata, Zip Co	rde)	
		20e.METHOD OF DISPOSITION  1 Buriel 2 Cremetion 3 Remo	oval from State come		OF DISPOSITION (Ne	eme of		CATION — City	y or Town, S	tate
		21. SIGNATURE OF FUNDINAL BETWICE UC	Wm. C. Brown Comm. F. H. 1206 W. North Ave						ve.	
		23. PART (Entar the diseases, or called the shock, or heart felture. If IMMEDIATE CAUSE (Finel disease or condition resulting in death)	complications that caused List only one cause on ea	ch line.	-11	1-1	haa cerdlec or resp bre aln As			Approximate interval Between Onset and Death
	IN: MEDICAL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in daeth) LAST	DUE TO (OR AS A	CONSEQUENCE OF	·):			use	>	
		PART II. Other significant condition	a contributing to death bu	1-not resulting i	n the underlying	g cause given in	Part I, 24a. WAS AN PERFOI	RMED?	AWAIL COMF OF D	E AUTOPSY FINDINGS ABLE PRIOR TO PLETION OF CAUSE EATH? YES 2 \( \subseteq \text{NO} \)
	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO	HOSPITAL: 1   Inpatient 2   ER/Outpa	tlent 3 DOA	OTHER:	ACE OF DEATH (Ch	6 Cher (Specify)			
	ву Рн	27. MANNER OF DEATH  1 Chatural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	26b. TIMI	URY WO	URN AT PRK? YES 2 NO	28d. DEŞCRIBE NOW	NJURY OCCUR	ED	
	ETED B	3 Suicide 8 Could not be determined					281. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
1 2 A 1	COMPLI		CIAN: To the best of my knowle R: On the basis of examination						ause(e) and	manner ee stated.
TO THE HOSPI TO THE FUNER De filed within IMPORTANT:	H	296. SIGNATURE AND TITLE OF CERTIFIER	Mall	105		29c. LICENSE NUN	IBER	29d. DATE SI	GNED (Mont	h, Def. Year)
	2	30. MANE AND ADDRESS OF FERSON WHO	COMPLETED CAUSE OF DEA	2 - /	Equini)	n Blvo	1. But.	Md.	2-12/	6
		APR 07 1993	na Davidoon-Rono							

		1 - STATE STATE REGISTRAR STATE OF MARYLAND / DEP	FICATE OF DEATH	REG. NO.							
1, 2, 3 should		1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH NONTH DAY YEAR 3. TIME OF DEATH							
		WALLACE J. CLIFTON  4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in vrs. linet brithde	JR.	₩04 072 93 2:59 P	• M						
		4. SOCIAL SECURITY NUMBER  5. SEX  1	MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreign Country) MD	1						
		9e. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN DR LOCATION OF D	1 11/10/32							
	0.0	3325 W.BELVEDERE AVE	BALTIMORE CI								
2	ECTO	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY 10c.	ITY, TOWN OR LOCATION	10d. INSIDE CITY	_						
-0020 ng phy damp	OIR	MD	BALTIMORE	1 TYES 2 NO							
	2.010		10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?							
	FUNERAL	2219 ELSINORE AVE	21216	U.S.A.							
	BY FUI	M   Linesan wenting v V wenting	13. WAS DECENDENT OF NISPA If yea, apecity Cuban, Maxic  1 YES 2 NO Specification of the second of t		NT.						
1215-002 r attending phy use as the but		15. DECEDENT'S EDUCATION (Specify only highest grade completed) (She kind	'S USUAL OCCUPATION If work done during most of working	16b. KIND OF BUSINESS/INDUSTRY	V						
21 20 Ed Or 10	once. COMPLET	Elementary/Secondary (0-12) College (1-4 or 5+)	use retired.)								
YLAND by the hospit be detached	4-	II IIAII AOD OT TUMOS OF		AME (First, Middle, Maiden Surname)							
MARY! retained by 5 should be	B 8	19a INCODMANT'S NAME (Bene/Driet)		FERGUSON CLIFTON  Route Number, City or Town, State, Zip Code)							
		WAREN OF THEOR	ELSINORE AVE BA								
BALTIMORE, I after death. Page 6 may be by the funeral director, page squoral.	at be		E OF DISPOSITION (Name of	OATE 20c. LOCATION — City or Town, State							
MO age 6 directo	er must	Comotory, Cramatory C	CEM. 4/8/								
ALTIMOR death. Page 6 ma	examiner	21. SIGNALONE OF POWERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FA ESTEP BROTH	OFFACILITY OTHERS FUNERAL HOME P.A.							
BA after de by the fu		23. PART L'Enter the diseasea, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest,									
24 hours filled in	event, the medical	JMMEDIATE CAUSE (Finel	nd of Head	ch as cardiac or respiratory arrest, Approximate Interval Batwo Onset and De							
P.O. BOX 687 of the certificate be executed and company physician and company in Hyglene prior to burial, or other traumattic expenses.	or other traumatic	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEDUENCE of the condition of the	OF):								
DS The d	를 그	PART II. Other significant conditions contributing to deeth but not resulting	in the underlying couse given in		IG\$						
RECOF equires that en signed b of Health a	MEDIC			PERFORMED?  1 YES 2 NO  AMALABLE PRIOR TO COMPLETION OF CAUSI OF DEATH?  YES 2 NO	E						
- B 8 9	N =	25. WAS CASE REFERRED TO MEDICAL	26. PLACE DF OEATH (Ch	eck anh one)	_						
OF VITAL PHYSICIAN: The law this certificate has with the State Dep	SICI/	EXAMINER?  1. YES 2 ND  HOSPITAL: 1   Inpatient 2   ER/Outpetlent 3   DOA	OTHER:	eX other (Specify) 3325 W.BELVEDERE							
OF V PHYSICIA this certif with the	PHY	27. MANNER OF DEATH 280 DATE OF IN HIPY 280 T	ME OF 28c. INJURY AT WORK?	284. DESCRIBE HOW INJURY OCCURED							
ON ON OING PA	is marked D BY PI	2 Accident Investigation 4-2-1993	M 1 YES 2 ND	SUBJECT SHOT							
OIVISION OR ATTENOING DIRECTOR: After Nours after death	00 III	3 Suicide 8 Could not be 4 Nomicide determined		26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
DIVISION OR ATTENDING P DIRECTOR: After t hours after death	PLET	29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the heat of	3325 W.BELEVDERE AVE								
	ANT: If item 2	(Check only one)  2 MMEDICAL EXAMINER: On the best of my knowledge, dasth occurrence one)			1.						
# H H H	를 Ш	29b. SIGNATINE AND TITLE OF CERTIFIER	29c. LICENSE NUI	MBER 29d. DATE SIGNED (Month, Day, Year)							
戶戶產	TO B	Nennis J. (hute up	O.C.M.	E. 4-3-1993							
2 2 3					_						
223		30. NAME AND ADDRESS OF PERSON WHID COMPLETED CAUSE OF GEATH (ITEM 27) (Ty		Baltimore, Maryland 212							



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is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 :	
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	1 • STATE REGISTRAR	STATE OF MARYLAND	/ DEPARTM	ENT OF HI ATE OF	EALTH AND I	MENTAL HYGIEN REG. NO.					
1	1. DECEDENT'S NAME (First, Middle, Last)  COPFOLA EN	EST ERNEST	COPPO	DLA	7° A 4 A92	2. DATE OF DEATH April 4,	1993	1. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER 220-14-6550	5. SEX 6. AGE (in yrs. 1 🕅 M 2 🗆 F 91	Inst birthday) IF U	THE DAYS	IF UNDER 24 HRS. HOURS MHV.	7. DATE OF BIRTH (Month, Day, Year) June 13,		BIRTHPLACE (State or Foreign Country)  Italy			
TOR	98. FACILITY NAME (If not institution, give street Good Samaritan H		9b.		More Ci		9c. COUNTY	Y OF DEATH			
DIRECTOR	100. STATE 10b. COUNTY		200	WN OR LOCATION				10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO			
	10a. STREET AND NUMBER	Baltimore City 1  101. ZIP CODE 109. CITIZEN OF WHA									
FUNERAL	4211 Parkwood Ave.	12. WAS DECEDENT EVER IN U.S.	ADMED	42 WM 0 DECE	21206	WE ORIGINA IN	U.S	.A.			
B	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES 2 () IF YES, GIVE WAR OR DATES	NO	If yes, spe	offy Cuben, Mexica 2 NO Specifi	NC ORIGIN? (Specify Yea in, Puerto Rican, etc.) y:	or No- 14	Black, White, etc. Specify:			
ED	15. DECEDENT'S EDUCA (Specify only highest grade of		DECEDENT'S USUA (Give kind of work of	AL OCCUPATION	N I of wadday	166. KIND OF BUS	SINESS/INDUS				
COMPLETED	Elementery/Secondary (0-12)	Coffege (1-4 or 5+) 2 yr S	Merch	red.)		Marke					
BE CO	17. FATHER'S NAME (First, Middle, Lest) Salvatore	Coppola Cecilia Russo									
5	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Town	n, State, Zip Co	ode)			
-	Mrs. Josephine M.	Coppola	Sam	ne as #	10						
	20a. METHOD OF DISPOSITION  1  Burlel 2 X Cremation 3 Remove 4  Donation 6 Other (Specify)	zel from State 20b. PLAC cemetery,	CEAND DATE OF DIS Cremetory or other p	SPOSITION (Name lace)	ce Carn	4/6/93 To	CATION - CH	y or Town, State			
	21. SIGNATURE OF FUNERAL SERVICE LICE	Paul L. Harts	ock,Jr.	22. NAME AND	ADDRESS OF FA	GLITY Baltin	nore, M	D 21214			
	taul Z. Ha	uboch of				Ruck Inc.		Harford Rd.			
		emplications that saused the lat only one cause on each li	death. Do not e ne.	enter the mod	e of dying, suc	h aa cardlac or respi	ratory arres	Interval Between			
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	LIVER ME	TASTASE	3				Onset and Death			
_	a.	DUE TO (OR AS A CONS	SEOUENCE OF):			·		7 .51/(			
Į O	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONS						2 0-41.			
RTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST	DUE TO (OR AS A CONS		nult				2 WK.			
CER	d.										
MEDICAL	PART II. Other algorificant conditions  A - FIB	contributing to death but no	t resulting in th	e underlyling	cause given in	Part I. 24s. WAS AN PERFOR 1 TYES 2	MED?	24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
								1 TYES 2 MO			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO	HOSPITAL:		HER:	CE OF DEATH (Ch						
	27. MANNER OF DEATH  1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJU WOR	RY AT	6 ☐ Other (Specify)  28d. DE\$CRIBE HOW II	NJURY OCCUP	RED			
ED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At building, etc. (Specify)	home, ferm, street,		ES 2 NO	261. LOCATION (Street a City or Town, State)	and Number or	Rural Route Number,			
COMPLET		IAN: To the best of my knowledge, On the basis of examination and/o									
ш	29b. SIGNATURE AND TITLE OF CERTIFIER		<u> </u>	, opinioni, de	29c. LICENSE NUN			GNED (Month, Day, Year)			
TO B	30, NAME AND ADDRESS OF PERSON WHO	OUKIAN M.D.	m, Y,6	+.	D44	209	▶ 4	4 193			

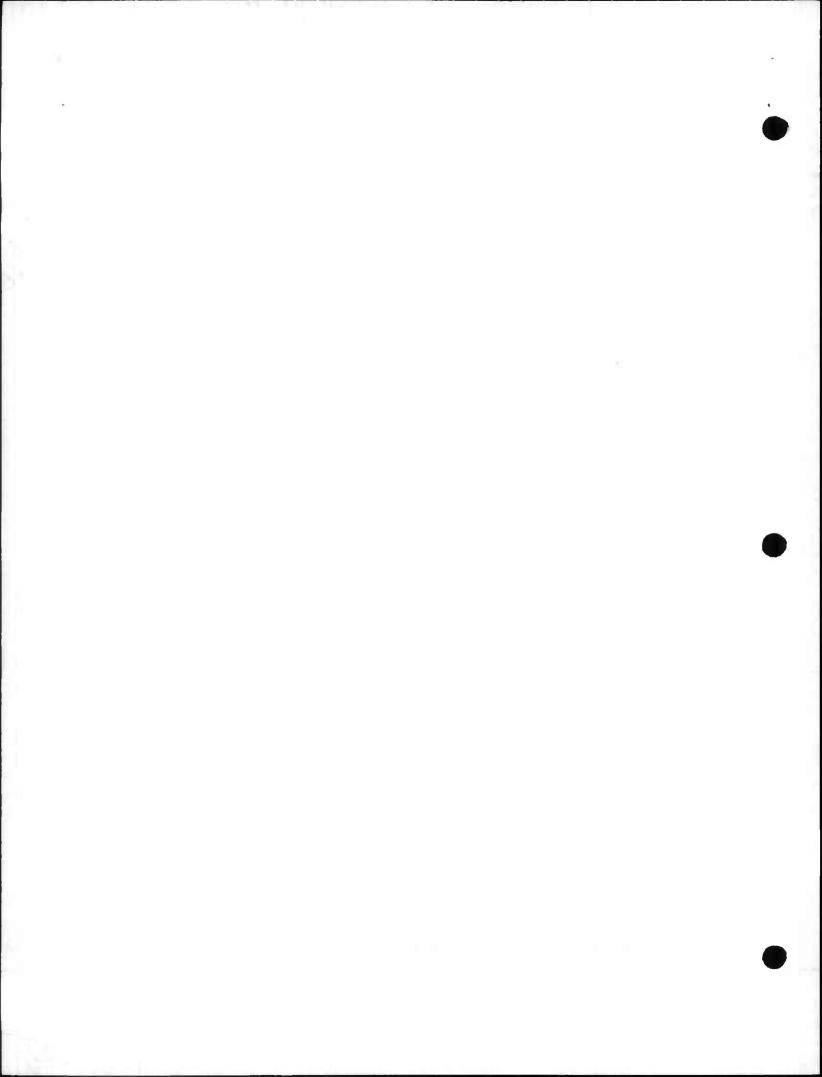
ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) Auc 32 REGISTRAD'S SIGNATURE 31. DATE FILED (Month, Day, APR -

2803

PAUL

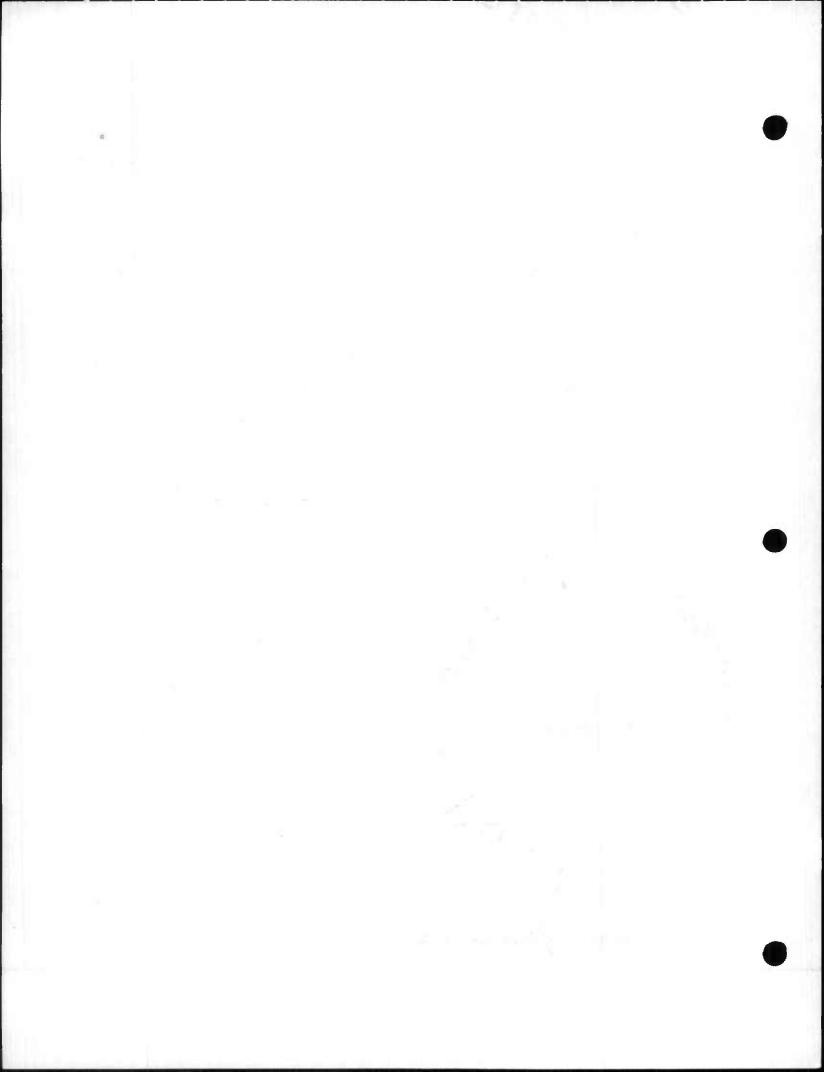
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3	I O	200	10
TIAS	VERA	hin 7	
E 15	E FU	DIM P	
TO THE MOSPITAL DE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be	HT C	B file	
E	F	ă	
1	6		
	~	-	

	1	1. DECEDENT'S NAME (First, SHIRLEY		ES MERCER	CHAMD	T Thi					2. DATE	OF DEATH		YEAR	3. TIME OF DEA	тн Р "
		4. SOCIAL SECURITY NUMB		T	AGE (In yrs. I		UNDER 1 YE	AR IF	F UNDER 24	I HRS.	7. DATE	OF BIRTH	1993	A. BIRTHE	PLACE (State or F	1 100
70	2	224-52-006	88	1 🗆 M 2 🖰 F	50	YRS.	ONTHS DA	Y8 H	IOURS	MIN.	1-14	1-43		Vir	ginia	
should	~	Sa. FACILITY NAME (If not in		· ·		9	b. CITY, TO				ATH		9c. COU	NTY OF DE	АТН	
1, 2, 3	5	THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY RESIDENCE OF DECEDENT														
Sages	DIRECTOR	10a. STATE	10b. COUNT	Υ		10c. CITY, 1			N						10d. INSIDE CIT LIMITS?	Υ
ili.	AL D	Virginia 100. STREET AND NUMBER				Winc	hest	_	IP CODE				I son CIT	ZEN OF W	1 ☑ YES 2 ☐	NO NO
nsit pe	ERA	108 Ash Hollow Dr. 22601 U.S.A.														
burial-transit permit. Pages	FUNER	11. MARITAL STATUS	<b>.</b>	12. WAS DECEDENT E			13. WAS	DECENE L specifi	DENT OF	HISPAN	IC ORIGIN	? (Specify Yes	or No-	14. RACE Black	- American Ind White, etc.	lan,
유	A	1 Never Married 2 Married 3 Widowed 4 Divorced FORCES? 1 YES 2 MO If yes, specify Cuban, Maxican, Puerto Rican, etc.)  1 YES, GIVE WAR OR DATES    If yes, specify Cuban, Maxican, Puerto Rican, etc.)   Bleck, White Specify:   Specify:   White Sp								te						
use as	E	15. DEC (Specify only	EDENT'S EDU highest grade	CATION completed)		DECEDENT'S US (Give kind of work	done durin	PATION g most of	of working		16b.	KIND OF BUS	SINESS/INC	USTRY		
od for	MPLET	Elementary/Secondary (0	-12)	College (1-4 or 5+)		deral E		ency	v Ma	nage	ement	Eme	rgen	ev Ma	nagemer	nt.
detach once.	COM	17. FATHER'S NAME (First, M.	iddle, Lest)							_	_	fiddle, Malden			ara g canca	
9 to	BEC	Milton F.		r				M	Mild	red	L. I	Mercer				
5 should notified	2	Enders Fune		OMA		196. MAILING AC 101 E.										
age a		20a. METHOD OF DISPOSITI	ON		20b. PLAC	E AND DATE OF I	DISPOSITIO	N (Name o		CLL	OATE	Y	CATION -		rn, Stata	
frector, j		4 Donation 5 Other	(Specify)		Prov.	idence	_				4-6	Cla	rk Co	o. Vi	rginia	
funeral di examiner		21. SIGNATURE OF FUNERAL	. SERVICE LIC	CENSEE	11				ADDRESS DWSO:			al Hom	e. In	nc.		
the fundal.	-	22 PADT I Enter the di	- 4	Ll	4	4-4-5	105	OY C	ork	Rd.	Tows	son, M	d. 2	L204		
or removal		23. PART I. Enter the di shock, or he IMMEDIATE CAUSE (Fin	ert fallure.	List only one cause	on each li	ne.	enter the	mode	or dyln	g, such	as cerd	lac or respi	ratory en	est,	Interval E Onset an	Between
ompletely fill f, cremation, event, the		disease or condition		a. PULM	ONA	RY E	DE	KM	_						14 hr	
al, crer		Carrie Constant									7 <				121	0.0
signed by the attending physician and completely filled in by the Health and Mental Hygiene prior to burial, cremation, or removal. was eny Injury, or other traumatic event, the medicel e	CATION	Sequentially list conditi	liate	b. ASPER											120	ays clays
ohysicia e prior	CA	Cause, Enter UNDERLYI CAUSE (Disease or inju	NG ry	C PROLON	JABI	) NEU	itri	OP	A A	IA	7				400	days
Hygiene por other	CERTIFI	that initiated events resulting in death) LAS				A PY						UTE MY	'ELOC	YTIC	(10)	ove.
Mental Jury,		PART II. Other significa	nt condition											Lau	-	
een signed by the att of Health and Menta shows eny Injury,	MEDICAL	TAIT II. Ollor	CONGREDE	is contributing to de	ati put not	resulting in	ne under	lying ca	ause gn	ren in i	Pairt I.	24s. WAS AN PERFOR	MED?		WERE AUTOPSY F AVAILABLE PRIOR COMPLETION OF	TO
Healt WS 6	MED										_	1 TYES 2	M NO		OF DEATH?	NO
as bee dept. o		East of													10	
State Dept State Dept Item 23	SICIAN:	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 THO	MEDICAL	HOSPITAL:	P/Outnotlant		THER:				ck only on					
s certification the sed, or	PHY	27. MANNER OF DEATH		28a. DATE OF IN.	JURY	28b. TIME O		INJURY WORK?	Y AT	dence		CRIBE HOW I	NJURY OC	CURED		
eath with marked	BY	2 Accident	Pending nvestigation				M 1	YES	2 🗌	NO						
ECTOR: After this certificate has been is after death with the State Dept. of n 28 is marked, or Item 23 sho	ETED		Could not be letermined	28e. PLACE OF II building, ato	Specify)	nome, farm, stre	et, factory,	office				ATION (Street a or Town, State)	and Number	or Rural Ro	oute Number,	
T Hours	1	41		CIAN: To the best of my												
Within ANT:	COMPL	2   MEDI	-	R: On the basis of exam	nination and/o	or Investigation, I	n my opinie	on, death	h occurso	at the	time, data	and place, an	d due to th	e cause(a)	and manner as	stated.
TO THE FUNERAL DIFECTOR STRONGS IMPORTANT: If Hem	BE (	29b. SIGNATURE AND TITLE	OF DEHTIFIED	il	سا	n	0.	29	9c. LICEN	SE NUM	BER		29d, DAT	SIGNED (	Month, Day, Year)	
,	٩	30. NAME AND ADDRESS OF	PERSON WH	O COMPLETEO CAUSE	OF DEATH (IT	EM 27) (Type, Pri	int)		. 1	1	1		, 42		21287	in
5		31. DATE FILEO (MORE), Depar	Andria LU	KULSZEW 142. REGISTRARIS	STATURE	M. D	, Ja	hns	sHo	pki	nsh	ospita	1, 5	alton	nore, N	10
		APR 06 19	93 8	funa Davidson	-Nonos	The state of the s										



1. DECEDENT'S NAME (First, Middle, Last)

RESIDENCE OF DECEDENT

10c. CITY, TOWN OR LOCATION

IF UNDER 1 YEAR | IF UNDER 24 HRS.

9b. CITY, TOWN OR LOCATION OF DEATH

Randallstown

DAVIS

6. AGE (In yrs. last birthday)

E

5. SEX

Baltimore County General Hospital

10b. COUNTY

1 M 2 F

2. DATE OF DEATH

7. DATE OF BIRTH (Month, Day, Year) 11-14-27

Jes 1, 2, 3 should

ECTOR

ii. Pa	ā	Maryland	Ва	ltimore			Wood	lawı	n			
permit.	3AL	10a. STREET AND NUMBER						101	ZIP CODE			
`	NER.	6413 Gilmo	re Ave						212			
11. MARITAL STATUS  1 Never Married 2 Married  3 Widowed 4 X Divorced  12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES  Korea									ENDENT OF HISPA ecify Cuban, Maxico 2 XNO Specia	en, Puerl		
be detached for use	ETED	15. DECI (Specify only Elementary/Secondary (0-	EDENT'S EDU highest grade	CATION completed) College (1-4 or 5+)	16.	(Give kind of IIIe. Do NOT	work done di			1	6b. KIND OF E	
ched 1	COMPL	12th				Offs	et Pro	essi	nan		Dep	
be detach	- 1	17. FATHER'S NAME (First, Mi							1e. MOTHER'S NA	HER'S NAME (First, Middle, Maide		
d bluc	BE	Norman  19a. INFORMANT'S NAME (7)	Aust	tin	Dav		0.4000000	101		Jani		
5 should notified	2	Mrs. Deborah		211v					nd Number or Aural			
page t be		20a. METHOD OF DISPOSITE	ON		20b. PL	ACE AND DATE	OF DISPOSIT	TION /Na	me of	_	Mt . A	
must		13 Burial 2 Cremation 4 Donation 5 Other		loval from State	Plea	y, crematory or as ant	other place) Ridge	Cen	netery	4/		
tuneral director, page J. examiner must be		21. SIGNATURE OF FUNERAL	SERVICE LIC	CENSEE	1.		22. N	AME AN	D ADDRESS OF FA	CILITY		
al.		Step	her.	M Hen	Ki	ns			ng Byers Liberty			
or removal.		23. PART I. Enter the di-	seases, or	complications that ca	sused th	e desth. Do	not entar t	the mo	de of dying, suc	th ss ca	ardiac or res	
ending physician and completely fille I Hyglene prior to burial, cremation, or other traumatic event, the	CERTIFICATION	ehock, or heert failure. Liet only one ceuse on each line.  IMMEDIATE CAUSE (Finel disease or condition) resulting in dasth)  Sequentially list conditions, if any, lasding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in dasth) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  d.										
has been signed by the att Dept. of Health and Menta 1 23 shows any injury.	N: MEDICAL	PAHI II. Other significan	nt condition	ne contributing to dea	ath but r	not resulting	In the und	leriyinç	) cause given in	Part I.	24a. WAS A PERF	
cate has State De item 2	PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL			OTHER		ACE OF DEATH (Ch	eck only	one)	
i he i	IXSI	1 YES 2 NO		HOSPITAL:			4 🗆 Nursi	ng Hom	5 - Residence			
this with	ВУ РН	1 Natural 5 🗆 F	Pending nvestigation	28s. DATE OF INJ (Month, Day, )		28b. TII	JURY M		JRY AT RK? ES 2 NO	28d. D	EŞCRIBE HOV	
CTOR: At after de 28 ls r	ETED 1		Could not be letermined	28s. PLACE OF IN building, etc.	(Specify)	U homa, farm,	street, factor	ry, office			CATION (Street ty or Town, Star	
TO THE FUNERAL DIRECTOR: After be filed within 72 hours after death IMPORTANT: If Item 28 Is mail	COMPLE			ICIAN: To the best of my								
TO THE FL be filed wit	TO BE (	29b. SIGNATURE AND TITLE	1800	sei	H	HYS	ESICII	AN				
		30. NAME AND ADDRESS OF AVTAI	2	s. B.	AS	SIN	e, Print)		B. C	C.	Ge. F	
		31. DATE FILEO (Month, Day, )	bar)	32. REGISTRAR'S	SIGNATU	RE						

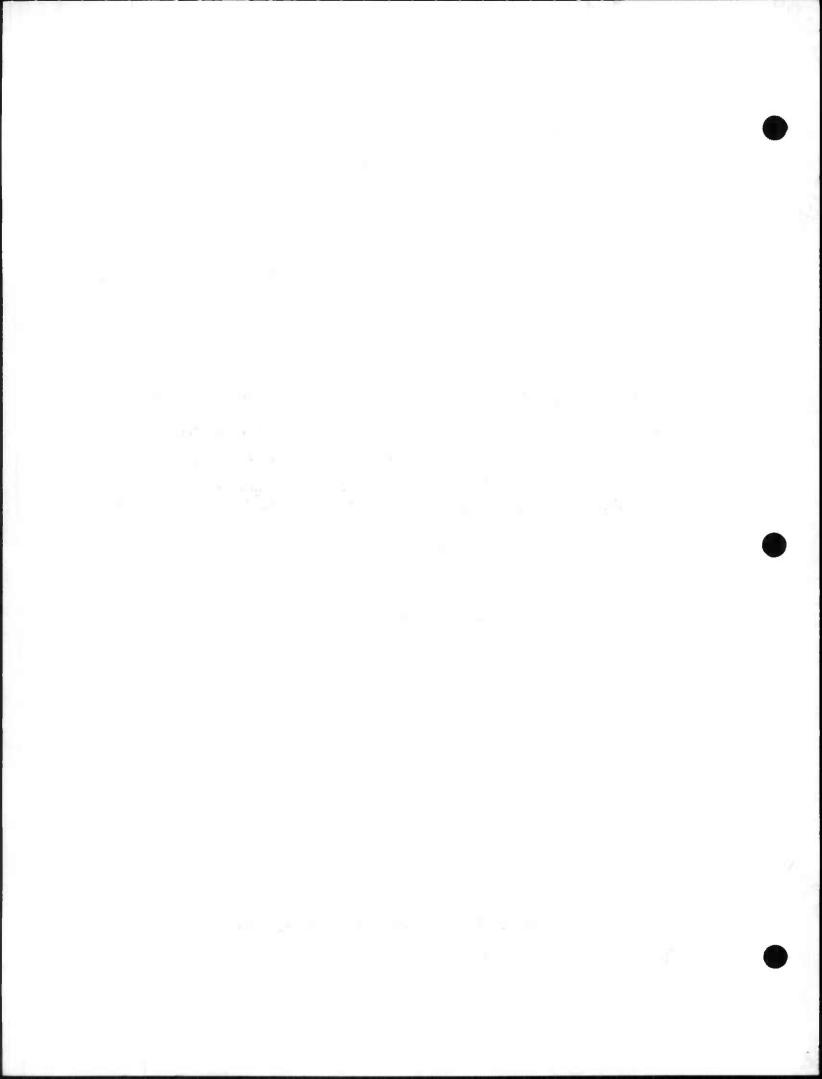
3. TIME OF DEATH 8. BIRTHPLACE (Sta Maryland 9c. COUNTY OF DEATH Baltimore 10d. INSIDE CITY LIMITS? 1 YES 2 X NO 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 14. RACE — American Indian, Black, White, etc. White USINESS/INDUSTRY t. of Army en Surname) Hughes own, State, Zip Code) Airy, MD 21771 LOCATION — City or Town, State oodbine, Maryland Directors, Inc. ndallstown, MD 21133 piratory srrest, Approximeta Intarval Between **Onset and Death** 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? N AUTOPSY 2 🗌 NO 1 YES 2 NO INJURY OCCURED t and Number or Rural Route Number, and due to the cause(s) end menner as stated. 29d. DATE SIGNEO (Month, Day, Year)

DHMH-18 Rev 1/89

Ι	tem12,19a,Film698,							3 09810		
	1 - STATE REGISTRAR	STATE OF MAI	RYLAND / DEPAI CERTIF	RTMENT OF I	HEALTH AND	MENTAL HYGIEN REG. NO				
1	1. DECEDENT'S NAME (First, Middle, Last)		02	TOATE OF	DEATH	2. DATE OF DEATH		3. TIME OF OEATN		
	KENNE		EINLEIN			03 31°	1993 <sup>v</sup>	12.000		
8	4. SOCIAL SECURITY NUMBER 213 30 5969	1 X M 2 □ F	AGE (In yrs. last birthday) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTIN (Month, Day, Year) 01/28/19	28 M	BIRTNPLACE (State or Foreign Country) ARYLAND		
TOR	9a. FACILITY NAME (til not institution, give : GREATER BALTIMORI RESIDENCE OF DECEMENT	,	CENTER	96. CITY, TOWN	ON LOCATION OF DI	EATN	9c. COUNTY BALT	Y OF DEATH IMORE		
DIRECTOR	10a. STATE 10b. COUNT	LTIMORE		BALTIMOR				10d. INSIDE CITY LIMITS? 1 YES 2 NO		
FUNERAL	1427 PROVIDENCE	E ROAD		10	zip code	286		J.S.A.		
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12, WAS DECEDENT EVEN FORCES? 12 XX IF YES, GIVE WAR W. 11 &	YES 2 NO OR DATES	If yes, sp	CENDENT OF NISPAR ecify Cubers, Maxica 2 NO Specifi	NIC ORIGIN? (Specify Yearn, Puarto Rican, etc.)		RACE — American Indian, Black, White, etc. Specify: WHITE		
IPLETED	15. DECEOENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION	16e. DECEDENT'S	= 1.5757	ON est of working	16b. KIND OF BU		TRY		
BE COMPL	17. FATHER'S NAME (First, Middle, Last) Christopher A.	Deinlein	Bulle	ier	16. MOTHER'S NA	<u>New Ho</u> ME (First, Middle, Maiden nia				
TO B	19a. INFORMANT'S NAME (Type/Print) Helen L. Dein		19b. MAILING 1427	Provide:	and Number or Rural I	Route Number, City or Tow Towson, Md	n, State, Zip Coo	de) 6		
	20a, METHOD OF DISPOSITION 1 Suriel 2 Commation 3 Rem 4 Donation Dipther (Specify)		20b. PLACE AND DATE comotory Gemetory or DULANCY	OF DISPOSITION (Na	ame of	OATE 20c, LO	cation - chy onium,	or Town, State		
	21. SIGNATURE OF FUNERAL SERVICE LI	chale	h-	Ruck 1050	York Rd.	uneral Hom Towson, M	d. 2120	04		
	23. PART I. Enter the diseases, or shock, or heert fellure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one cause	used the death. Do on each line.		de of dying, suc	h as cardiac or resp	ratory arrest	Approximata Interval Batween Onset and Dasth		
NC	Sequentielly list conditions.	■ HEPATIC	AS A CONSEQUENCE OF INSUFFICE	ENCY AND	COMA			2 WKS		
ERTIFICATION	If any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury	CIRT	AS A CONSEQUENCE OF					2 475		
CERTII	that initiated events resulting in death) LAST	d	AS A CONSECUENCE O	··· ):						
PHYSICIAN: MEDICAL	PART II. Other significant condition	ns contributing to dee	eth but not resulting	In the underlying	g causa given in	Part i. 24a. WAS AN PERFOR	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 70		
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				ACE OF OEATH (Che	ack only one)				
YSI	1 TYES 2 NO	HOSPITAL: 1 Inpetient 2 I ER		OTHER: 4 Nursing Hom	e 5 🗆 Residence	6 Other (Specify)				
ВУ РН	27. MANNER OF OEATH  1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJI (Month, Day, Y	bar) IN	JURY WO	RK? /ES 2 NO	28d. DESCRIBE HOW I	NJURY OCCUR	ED		
	3 Suicide 6 Could not be 4 Homicide determined	28e, PLACE OF IN building, etc.	JURY — At home, farm, (Specify)	atreet, factory, offic	•	261. LOCATION (Street a City or Town, State)	and Number or F	Rural Route Number,		
COMPLETED		ICIAN: To the best of my						iuse(a) and manner or stated,		
BE	296. SIGNATURE AND TITLE OF CERTIFIED	utoliett,	2. m	D.	29c. LICENSE NUM  29c. LICENSE NUM	832		GNED (Month, Day, Year) uls 31, 1993		
DT	30. NAME AND ADDRESS OF PERSON WH	o completed cause o ack C. Mit	chell M.D.							

APR 06 1993

32. REGISTRAR'S SIGNATURE



	FOR 1 - STATE REGISTRAR	STATE OF MARYLAN	ID / DEPARTME CERTIFICA	NT OF H	EALTH AND	MENTAL	HYGIENE REG. NO.	2	) (	301
	1. DECEDENT'S NAME (First, Middle, Lest)	BEATRICE	EVANS ANS			2. DATE O		13	3. TIME OF	DEATH M
	A. SOCIAL SECURITY NUMBER  20326 4440  Se. FACILITY NAME (SIJICE INSTITUTION, give a	10 M2 10 63	YRS. MONTH		IF UNDER 24 HRS. HOURS MIN.	12	103/29	B. BIRTH	gINI	or Foreign
DIRECTOR	RESIDENCE OF DECEDENT  10s. STATE  10s. COUNTY	more Stree	A	Balt	more	2	FL. 600	NIT OF D		
	Maryland		B	refi	NOVE				10d. INSIDE	? 2 🔲 NO
FUNERAL	11. MARITAL STATUS	n MEdical Center D1230 U.S								
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES 2	Z X MO	If yes, spe 1 YES	ocify Cuban, Mexics	an, Puario Ric	(Specify Yas or No-	14. RACE Black Specif	American White atc.	indian,
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION 18: Completed) 28: Coffege (1-4 or 5+)	a. DECEDENT'S USUAL (Give kind of work do life. Do NOT use retired	OCCUPATIO ne during mos d.)	N st of worlding	16b. K	(IND OF BUSINESS/IND	USTRY		
CON	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Mic	ddle, Meiden Sumame)	_		
BE (	JEFFS BANKS				MARY	CLAR	K			
TO	19e. INFORMANT'S NAME (Type/Print)						; City or Yown, State, Zip	Code)		
	MATTIE EVANS 20a. METHOD OF DISPOSITION					ALTO.	MD 21229			
	1 Donallon 5 Other (Specify)	oval from State Cemeter	ACE AND DATE OF DISP	ce)		OATE	20c. LOCATION		vn, Stata	
	21. SIGNATURE OF FUNERAL SERVICE LIC		UDON PARK	2. NAME AN	D ADDRESS OF FA	2/93 VCILITY	BALTO.	MD		
-	1000	3/16	) 1	ESTE	P BROTHE	RS FUI	NERAL HOMI			
	23. PART L'Enter the diseases, or c	omplications that causad th	e daath. Do not ant	ar the mod	EUIAW P	LACE I	BALTO. MD	2121		oximata
	shock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	A Silverov	Lo Ry		lure		o or roop.iatory air	out,	intary	ai Between
1		DUE TO (OR AS A CO	NSEQUENCE OF):	000	4.00					
ō N	Sequentially list conditions,	OUE TO (OR AS A CO	NSEQUENCE OF:	V 7	6				-	
S	cause. Enter UNDERLYING CAUSE (Disease or injury	1 66	ocin.	ul		5600	ch			
	that initiated events resulting in death) LAST	OUE TO (OR AS A CO	NSEQUENCE OF):	0						
CERTIFICATION	death LAST	1	· Ale	10					_	
AL.	PART ii. Other significant conditions	eleter			cause givan in		4a. WAS AN AUTOPSY PERFORMED?		WERE AUTOP AVAILABLE PI COMPLETION	RIOR TO
PHYSICIAN: MEDIC	14760	Alden	new	ص					DF DEATH?	□ NO
AN	OF 1880 0405 05550000 110 110 110 110 110 110 110	Hork wig	1							
Sign	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	ОТН	ER:	ACE OF DEATH (Che					
HYS	1 YES 2 NO 27. MANNER OF DEATH	1 Shpatlant 2 ER/Outpatien 28a. OATE OF INJURY	28b. TIME OF	ursing Home 28c. INJU	5 Rasidence					
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	WOR	ES 2 NO	28d. DESCH	RIBE HOW INJURY OCC	URED		
	3 Suicida 8 Could not be determined	26s. PLACE OF INJURY — A building, etc. (Specify)	At home, farm, street, fa	ictory, office		281. LOCATION OF THE CASE OF T	ON (Street and Number Town, State)	or Rural Ro	ute Number,	
LE I	29a. CERTIFIER (Check only	CIAN: To the best of my knowledge	a. death occurred at the	time data a	and place, and thus	to the counci	(0) and manner at the			
COMPLETED	one) 2 MEDICAL EXAMINER	3: On the basis of examination and	d/or investigation, in my	opinion, de	ath occured at the	time, data an	d place, and due to the	ceuse(e)	end menner	an stated.
TO BE (	29b. SIGNATURE AND TITLE OF CERTIFIER	PHSician		-	29c. LICENSE NUM	IBER 248	29d, DATE	SIGNED	Month, Day, Y	tear)
F	30. NAME AND ADDRESS OF PERSON WHO		(ITEM 27) (Type, Print)	-10	1-1	м -	M	7		
				and an all H	11' 4 1				11	_
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATUR	TOKAO - O	sall	" or he	10	in with		2(22	9.

BALTIMORE, MARYLAND 21215-

rmit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attend TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filted in by, the funeral director, page 5 should be detached for use as the filed within 72 hours after death with the State Dept. of Health and Mental Hygiene Brier, to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

ITEMS: 23 PARTI , II, 27,28a-f, PER MEO G-698 4/23/93

	1 - FOR t.t STATE REGISTRAR	STATE OF MARYLAND	/ DEPARTI	MENT OF HE	EALTH AND DEATH	MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH	
	Betty j	Freund				03 3		5:03 P,M	
		SEX 8. AGE (In yrs.	HC HC	UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRT	HPLACE (State or Foreign	
		□ M 2 🔀 F 66	YRS.			2-18-1927		enna	
<u>~</u>	9e. FACILITY NAME (If not institution, give street				LOCATION OF D		9c. COUNTY OF I	DEATH	
DIRECTOR	2542 Fait Ave	nue		Baltim	ore Ci	.ty			
1 2	10a. STATE 10b. COUNTY			OWN OR LOCATIO	ON			10d. INSIDE CITY	
	Maryland	na	Ba.	Ltimore				LIMITS? 1 YES 2 NO	
3AL	10e. STREET AND NUMBER			101.	ZIP CODE		10g. CITIZEN OF		
FUNERAL	2542 Fait Avenue				21	224	USA	A	
E	11. MARITAL STATUS 12 1 Never Married 2 Married	P. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2				NIC ORIGIN? (Specify Yes		E — American Indian, k, White, etc.	
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES	no	1 TYES 2	2 NO Specif	y:	Spec	White	
0	15. DECEDENT'S EDUCAT (Specify only highest grade con	ION 16a.	DECEDENT'S US	UAL OCCUPATION	1	16b. KIND OF BUS	INESS/INDUSTRY	MILCO	
Ш			(Give kind of work life. Do NOT use re	done during most tired.)	of working	_ Sec	curity one Opera		
COMPLETED	Grammer					Telepho	one Opera	ator	
8	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden	Sumame)		
BE	Rudie Stephens  190. INFORMANT'S NAME (Type/Print)					na Baker			
2	Beverly Gress					Route Number, City or Town Balto, MD 2			
	20a. METHOD OF DISPOSITION	I got by at							
	1 Buriel 2 Cremation 3 Remove 4 Donation 5 Other (Specify)		CEAND DATE OF D crematory or other		e or	OATE 20c. LO	CATION — City or To	own, State	
	21. SIGNAPORE OF FUNDIAL SERVICE LICENS	Ronald Wad	e, Dir	22. NAME AND	ADDRESS OF FA	CILITY State	natomyBo	ard	
	4/3/93   655W.Baltimore St,Balto,MD 21201								
	23 PART I. Enter the diseases, or com	polications that caused the	death Do not	enter the mod	a of dulage aug	h an anglian as social			
	anock, or meant failure. Lies	t only one cause on each it A L P R O Z O L A M	na.	ICATIO		it as cerdisc or reapi	ratory arrest,	Approximata interval Between	
1	IMMEDIATE CAUSE (Final disease or condition	ALFRYZULAN	TINION	ICALIO	111	1.		Onset and Daeth	
	resulting in death) a	DUE TO (OR AS A CONS	SEOUENCE OF):		********	E BOOK			
Z	Sequentially list conditions, b							ļ	
Ĕ	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONS	SEQUENCE OF):						
[윤]	CAUSE (Disease or injury C	DUE TO (OR AS A CONS	SECULENCE OF						
CERTIFICATION	that initieted events resulting in death) LAST	50C 10 (511 A5 A 501)	DEGOLINCE OF J.						
	0								
N N	PART II. Other aignificant conditions c					DEDECOR		WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO	
ă	Deposition A	RIFRIOSCLER	OTIC C	ARDIOV	ASCULA	1 TYES 2	Z(NO	OF DEATH?	
X	DISEASE							1 TYES 2 NO	
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL			20.01.4	OF OF BEATH (0)				
딣	EXAMINER?	OSPITAL:  Inpatient 2 ER/Outpatient		THER:	CE OF DEATH (Ch				
H	27. MANNER OF DEATH	28e. DATE OF INJURY	28b, TIME O	28c, INJUE		8 Other (Specify)  28d. DESCRIBE HOW IN	LIURY OCCURED		
	Netural 5 Pending	(Month, Day, Year) 3 / 3 0 / 9 3	U N K		K? S 2 🔯 NO	UNKNOWN			
D BY	3 Suicide 8V/Could and he 28s. PLACE OF INJURY — At home, farm, street, factory, office 28s. LOCATION (Street and Number or Rural Route Number								
TED	4 Homicide determined	H O M E				2542 FAI	T AVE.		
COMPLET	29a. CERTIFIER (Check only 1 CERTIFYINO PHYSICIAN	Y: To the best of my knowledge,	death occurred a	the time, date as	nd place, and due	to the cause(a) and man	ner as stated.		
8 0		In the basis of examination and/o						a) and manner as stated.	
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER			- :	29c. LICENSE NUM	IBER	29d. DATE SIGNED	(Month, Day, Year)	
10 B	Wonald &	Wrightm	0		O.C.1	M.E.		01/1993	
F	30. NAME AND ADDRESS OF PERSON WHO CO								
	DONALD G. WRIGHT			Stree	t, Bal	timore, M	larylan	d 21201	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE	- Rudard						
	ΔPR 07 1993	1	· land	-					



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page the within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

DHMH-18 Rev 1/89

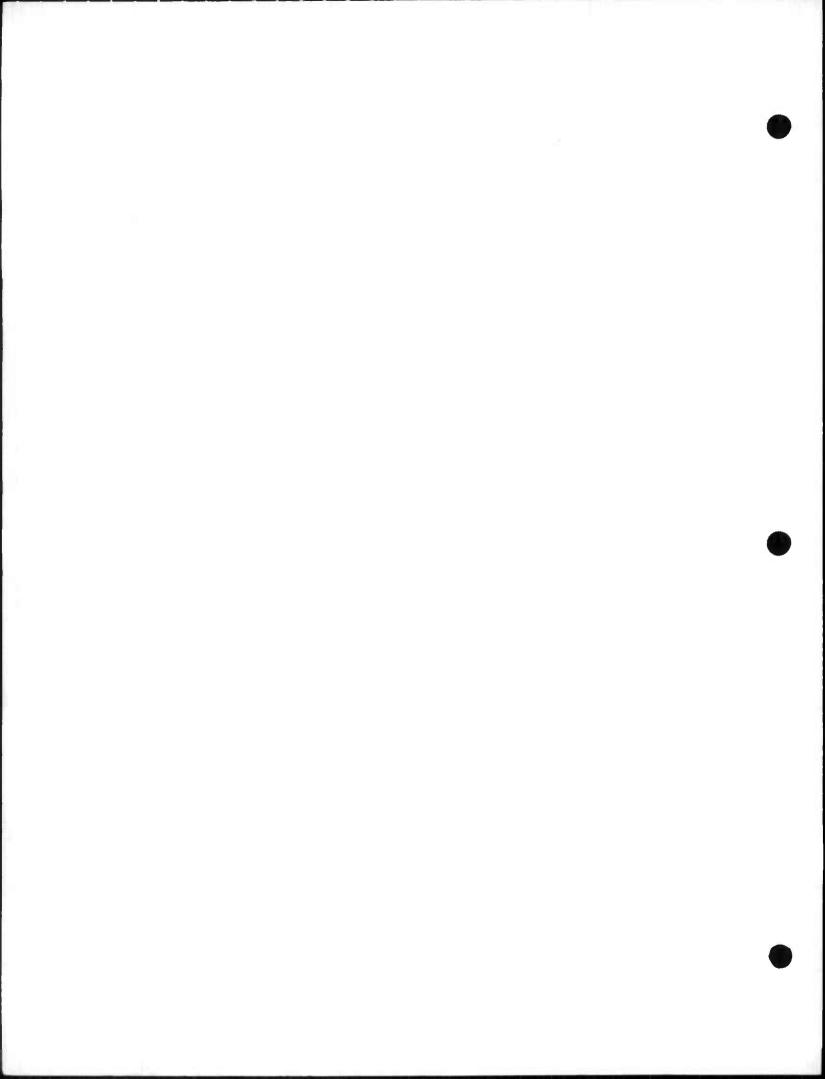
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		1 - FOR STATE REGISTRAR	STATE OF MARYLAN				HEALTH AND	MENTAL HYGIEN			0,5015
		1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH		3	. TIME OF DEATN
			RANKLIN, SR.					APRIL 0		93	4:20 A. M
		4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (In y		MONTHS	1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year)	1	. BIRTHPL Country)	ACE (State or Foreign
P		212-05-7790	1 x M 2 □ F 79	Y	RS.		0.00	June 25,	1913		land
2, 3 should	œ	9a. FACILITY NAME (if not institution, give s 1350 Sargeant S			9b. CITY		OR LOCATION OF D	PEATH	9c. COUNT	Y OF DEA	ТН
2,	O.	RESIDENCE OF DECEDENT				BAL	TIMORE				
physician. burial-transit permit. Pages 1,	DIRECTOR	10a. STATE 10b. COUNTY	1	10	c. CITY, TOWN C	R LOCA	ATION		-	10	Dd. INSIDE CITY
.≓. 23	ō	MARYLAND					BALTIMOR	E		,	LIMITS? YES 2 NO
med	IAL	10e. STREET AND NUMBER				10	of. ZIP CODE			N OF WH	AT COUNTRY?
an. ransit	FUNERAL	1350 Sargeant S	t.				21230		U.S.	Α.	
rysicia urial-t	F	11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEDENT EVER IN U. FORCES? 1 YES			NAS DE	CENDENT OF NISPA	NIC ORIGIN? (Specify Yes	or No- 1	I. RACE -	American Indian, Vhita, etc.
as the b	ВҰ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATE	S			S 2 XNO Speci		1	Specify:	White
attend e as	ED	15. DECEDENT'S EDU	CATION 16	a. DECEOE	ENT'S USUAL OC	CUPAT	ION	16b. KIND OF BU	SINESS/INDU	TRY	
the hospital or attr detached for use once.	Ш	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kir life. Do N	nd of work done o VOT use retired.)	luring m	ost of working				
ched ched	COMPL	9th		Fire	eman			Baltim	ore Ci	ty F	ire Dept.
detach once.	00	17. FATHER'S NAME (First, Middle, Last)						AME (First, Middle, Maiden			
aid be	B	James B. FRANK	CLIN				Sarah	C. BROO			
24 hours after death. Page 6 may be retained by the hospital or attending physician filled in by the funeral director, page 5 should be detached for use as the burial-tran ion, or removal.	2	19a. NAFORMANT'S NAME (Type/Print) Charles J. Frank	din, Jr.				Rd, Phoe	Route Number, City or Townix, MD 2	n, State, Zip C	ode)	
may be x. page st be		20a. METHOD OF DISPOSITION 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rame	20b. PL	ACEANDO	ATE OF DISPOS	TION /N	leme of	OATE 20c. LO	CATION — CH	y or Town	, Stata
director, per must		4 Donation 5 Other (Specify)	Mea	dowr	idge Me	mor	ial Park	4/08 E1k	ridge,	MD	
death. Pag tuneral di 1. examiner		21. SIGNATURE OF TUNERAL SERVICE/LIC	ENGER				ADD TIME		ING		
ter death. P the funeral yval.		Tours .	Smik -		4	107	WILKENS	RAL HOME, AVENUE-BAI	TTMOR	E. M	D. 21229
ours after d in by the or removal		23. PART I. Enter the diseases, or o shock, or heart failure.	complications that caused th Liat only one cause on each	e death. line.	Do not enter	the me	oda of dying, suc	ch as cardiac or reapi	ratory arres	it,	Approximata interval Between
y filled in tion, or re the med		iMMEDIATE CAUSE (Final disease or condition	Aug 1	PMI	20-1-		April 1	la Dia			Onset and Death
nted within 24 completely fills ial, cremation, event, the		resulting in death)	DUE TO (OR AS A CO	INSEQUEN	CE OFI	- /	eng 9	anene			
executed within and completely o bunal, cremat matic event, 1	_		Cardi	m	sha	Kes	- 0				
	CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CO	NSEQUEN	CE OF	A					
ficate be physician ne prior t	S	cause. Enter UNDERLYING CAUSE (Disease or injury	17.5.	C-4	V D	U					
ertifical ing phy giene p	E	that initiated events	DUE TO (OR AS A CO	NBEQUEN	CE OFF						
death certifi attending intal Hygien	ER	resulting In daath) LAST									
Me Me	AL C	PART ii. Other significant condition	s contributing to death but i	not reault	ting in tha un	derlyin	ng cause given in	Part I. 24a, WAS AN	AUTOPSY	1 24b. W	ERE AUTOPSY FINDINGS
that the ned by the and any in	2							PERFOR	IMED?	AV	AILABLE PRIOR TO IMPLETION OF CAUSE
requires tha leen signed of Health a shows any	MEDIC							1   YES 2	∐ NO	1	DEATH?
w required been pt. of 3					-			_		'	YES 2 NO
SICIAN: The law certificate has b the State Dept.	PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				28. P	LACE OF OEATH (C)	neck only one)			
iclan: ertificat the Sta	Sic	1 YES 2 NO	HOSPITAL: 1   Inpatient 2   ER/Outpatie	nt 3 🗆 D	OA 4 Nurs		ne 5 Rasidence	6 Other (Specify)			
PHYSIC this cer with th	H	27. MANNER OF OEATH	28a. OATE OF INJURY (Month, Day, Year)	28b	. TIME OF	28c. IN.	JURY AT ORK?	28d. DESCRIBE HOW II	NJURY OCCU	RED	
DING PHYS After this c death with marked,	B	1 Netural 5 Pending 2 Accident Investigation			М	1 🔲	YES 2 NO				
TTENDI TOR: A after d	ETED.	3 Suicide 6 Could not be 4 Homicide detarmined	26a. PLACE OF INJURY — building, atc. (Specify)	At home, to	erm, street, facto	ery, offic	00	261. LOCATION (Street a City or Town, State)	and Number or	Rural Rout	e Number,
DIRECT HOURS	7	29a. CERTIFIER (Check only 1 CERTIFYING PHYSIC	CIAN: To the best of my knowledg	e, death or	ccurred at the th	ne. data	and place, and due	to the cause(s) and men	nor se stated		
OSPITAL UNERAL Ithin 72 ANT: If	COMPL		R: On the basis of examination an								id menner as stated.
UNER TANT:	D H	296. SIGNATURE AND TITLE OF CERTIFIES	A NA 3	_		-	29c. LICENSE NU				onth, Day, Year)
CALE.	0	0///	115	5.55			D 14	771		-5-	
110	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF GEATH	(ITEM 27)	(Type, Print)	0			-		
-	- 11	DR. MOHAMMAD AFZA	∟ - 9055 CHEVE	COLET	DRTVE-	-SII:	LTE-203-1	ELLICOTT CI	TY M	D '	21042

31. DATE FILEO (Month, Day, Year)

APR 07 1993

32 REGISTRAR'S SIGNATURE



YEAR

9c. COUNTY OF DEATH

3. TIME OF DEATH

P. M

1:30

8. BIRTHPLACE (State or Foreign

2. DATE OF DEATH

7. DATE OF BIRTH

04-04-93

06-04-11

4. SOCIAL SECURITY NUMBER

289-16-1665

Se. FACILITY NAME (If not institution, give street end number)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

9b. CITY, TOWN OR LOCATION OF DEATH

FULLER

YRS.

HELEN

1 I MEX F

5. SEX

A.

6. AGE (in yrs. last birthday)

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DIRECTOR CHARLESTOWN RETIREMENT COMM. CATONSVILLE BALTIMORE RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE CATONSVILLE 1 YES XX NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 715 MAIDEN CHOICE LANE 21228 U.S.A. burial-transit 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES XXNO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES NO Specify: 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY Widowed 4 Divorced the WHITE COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY use (Specify only high page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5 +) DEPARTMENT STORE SALESPERSON 12+ 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) RAYMOND **ACKERMAN** MARGARET notified at RAMSEY BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 J. DUMAIS RICHARD 7 SAINT PAUL ST., BALTIMORE, MD. 21202 9 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State director, must GREENMOUNT CREMATORY BALTO., CITY examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY n by the funeral c removal. HENRY W. JENKINS & SONS CO. William 4905 YORK RD. BALTO, MD. medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, filled in by Approximate shock, or heart failure. List only one cause on each line. Interval Between 0 **IMMEDIATE CAUSE (Final** Onset and Death nding physician and completely fille Hygiene prior to burial, cremation, the disease or condition\_ drybration (DEHYDRATION) event, 1 resulting in death) OUE TO (OR AS A CONSEQUENCE OF) (DEMENTIA) Re traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING signed by the attending physician Health and Mental Hygiene prior to CAUSE (Disease or injury other 1 DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 Injury, PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? MEDICAL 24a. WAS AN AUTOPSY any 1 TES XX NO Shows 1 | YES 2 | NO has been of h PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

1 U YES NO 26. PLACE OF DEATH (Check only one) Hem THE HOSPITAL OR ATTENDING PHYSICIAN: The THE FUNERAL DIRECTOR: After this certificate I filed within 72 hours after death with the State: HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA Nursi me 5 - Residence 8 - Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY 26d, DESCRIBE HOW INJURY OCCURED marked, Netural 5 Pending Investiga 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street end Number or Rurel Route Number, City or Town, State) 90 COMPLETED 6 Could not be Item 28 4 Homicide CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated TO THE FUNERAL ID FINE FUNERAL ID FIRE WITHIN 72 H 2 MEDICAL EXAMINER: On the beele of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE and 14/4/93 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 7 11 Marker Charcologo plebaum mo 31. DATE FILED (Month, Day 3. REGISTRAR'S SIGNATURE 1993 when Deviden DHMH-16 Rev 1/89

HELEN FULLER

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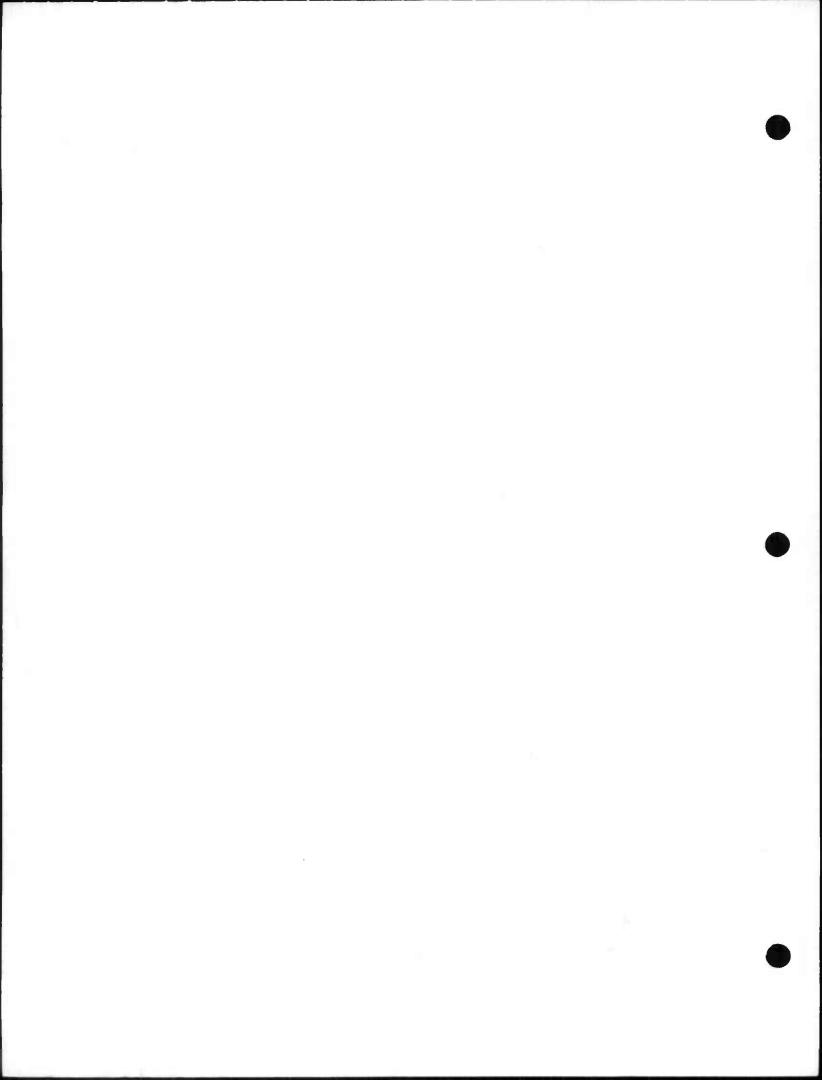
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Page 6 may be retained by the hospital or attending	director, page 5 should be detached for use as the		on much he notified of some
VSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	tending physician and completely filled in by the funeral	h the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	for them 23 shows any injury or other transmission and available available to metition at
A ATTENDING PHYSICIAN: The law requires that the dea	HECTOR: After this certificate has been signed by the att	urs after death with the State Dept. of Health and Menta	m 28 le marked or Hem 23 chouse any Injury
日日	TO THE PRINCIPAL TO	be filed water 2 ho	IMPORTANT: If He

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF H	EALTH AND N	MENTAL HYGIEN		,0 0001.			
	1. DECEDENT'S NAME (First, Middle, Last	)		2. DATE OF DEATH		3. TIME OF DEATH					
	WILLIAM A.	GORMAN, SR.				APRIL 4		9:05 P. M			
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (I		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIR	THPLACE (State or Foreign			
	705-07-9337	1⊠M2□F 88	YRS.	NONTHS DAYS	HOURS MIN.	(Month, Day, Year) Jan. 24, 190	Cou	RYLAND			
	90. FACILITY NAME (If not Institution, give ST. AGNES HOSPIT	street end number)		96. CITY, TOWN C	OR LOCATION OF DE		9c. COUNTY OF				
DIRECTOR	51. AGNES NUSEL.	IAL		BALTIM	ORE						
ᇈ	RESIDENCE OF DECEDENT  10a, STATE  10b, COUN	TV	1								
I BE			10c. CITY,	TOWN OR LOCAT				10d. INSIDE CITY LIMITS?			
	MARYLAND BAT	LTIMORE		BALTI				1 YES 2 NO			
RA				101	. ZIP CODE		4	WHAT COUNTRY?			
FUNERAL	921 CIRCLE DRIVE	12. WAS DECEDENT EVER IN	II & ADMED	140, 400, 000	21227			S.A.			
	1 Never Married 2 Married	FORCES? 1 YES	2 NO	It yes, sp	ecify Cuben, Mexican	IC ORIGIN? (Specify Yee n, Puerto Rican, atc.)	Ble	CE — American Indian, ick, White, etc.			
ВУ	3 Widowed 4 Divorced	IF TES, GIVE WAR ON DA	il ES	1 L YES	NO Specify:	*	Spo	WHITE			
ED	15. DECEDENT'S ED (Specify only highest grad	UCATION fo completed	16a. DECEDENT'S U	SUAL OCCUPATION	ON .	16b. KIND OF BUS					
Щ	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use		•						
MP	8TH GRADE		ASS T	FOREMAN		B & O R	AILROAD				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAM	ME (First, Middle, Maiden :	Sumeme)				
BE	JOHN GORMAN				BERTI	HA SUMMER					
2	19e. INFORMANT'S NAME (Type/Print)					loute Number, City or Town					
-	WILLIAM A. GORMA	AN, JR.	4 LA	UREL CO	URT-STEWA	ARTSTOWN,	PA. 173	363			
	20e. METHOD OF DISPOSITION 1		PLACE AND DATE OF				CATION — City or	Town, State			
	4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE L	// 0	LEN HAVE				LTIMORE				
	21. SIGNATURE OF PURENAL SERVICE L	TOTAL STATE OF THE PARTY OF THE	//		D FIINERA	L HOME, IN	C				
	with to	- Lobox		4107 W	TIKENS A	VENUE-BALT	TMORE.	MD, 21229			
	23. PART I. Enter the diseases, or	complications that chused . List only one cause on ee	the deeth. Do no	t enter the mo	de of dying, such	as cerdiec or respir	ratory errest,	Approximete			
	IMMEDIATE CAUSE (Final	1			,			Interval Between Onset and Daath			
	disease or condition resulting in death)	· Unto	acono	loral	her	ronte	ap c	howers			
		DUE TO (OR AS A	CONSEQUENCE OF)				1	100			
Z	Sequentially list conditions, b.										
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):								
걸	CAUSE (Disease or Injury	C	CONSEQUENCE OF								
Ē	thet initiated eventa reaulting in death) LAST	DUE TO (OR AS A	CONSECUENCE OF):								
E		d									
A P	PART II. Other aignificent condition	ne contributing to deeth bu	t not resulting in	the underlying	cause given in F			b. WERE AUTOPSY FINDINGS			
200						PERFORI		COMPLETION OF CAUSE			
M								OF DEATH? 1 YES 2 NO			
ä											
동	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			ACE OF DEATH (Chec	ck only one)					
PHYSICIAN: MEDIC	t TYES 2 NO	1 I Inpatient 2 ER/Outpa		OTHER:        Nursing Home	5 Residence 6	Other (Specify)					
H	27. MANNER OF OEATH	26e. DATE OF INJURY (Month, Day, Year)	26b. TIME INJUI	OF 26c. INJE	URY AT	26d. DESCRIBE HOW IN	JURY OCCURED				
BY	1 Netural 5 Pending 2 Accident Investigation	17 = 11.0=		M 1 🗆 Y	ES 2 NO						
ED	3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF INJURY - building, etc. (Specif	— At home, farm, str	eet, factory, office		261. LOCATION (Street at City or Town, Stets)	nd Number or Rura	Route Number,			
ETE	4 Homicide determined										
7	29e. CERTIFIER (CHOCK-ONLY 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated.										
COMPLET	MEDICAL EXAMINER: On the besis of exemination and/or investigation, in my opinion, death occurred at the time, data end place, end due to the ceuse(e) and menner as stated.										
BE C	296. SIGNATURE AND TITLE OF CERTIFIC	m 2000			29c. LICENSE NUMI	BER	29d. DATE SIGNE	O (Month, Day, Year)			
	. allrence	Valla	2P97,1	^	201	786	D 4- :	5-93			
2	DR. LAWRENCE GAT	HO COMPLETED CAUSE OF DEA LLAGER - SUITE	E 300-345	5 WILKE	NS AVENU	E-BALTIMOR	E, MD.	21229			
	31. DATE FILEO (Month, Day, Year)  32. REGISTRAR'S SIGNATURE  APR 0.7 1993										



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ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	The Feet of the Control of the confictate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	The second state death with the State Dept. of Health and Memai Hygiene prior to burial, cremation, or removal.	ORTANT: I item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE	TO THE	be files	IMPORT

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO I. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH OF-4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX 7. DATE OF BIRTH (Month, Day, Year) BIRTHPLACE (State or Foreign Country) South Carol IF UNDER 1 YEAR | IF UNDER 24 HRS. -09-185 1 M 2 | F MONTHS DAYS HOURS MIN Caroli YRS. 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DeA 105 DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY mD, 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP COOE 10g, CITIZEN OF WHAT COUNTRY? 611 South Charles Street 21230 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 VES 25 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married Widowed 4 Divorced BY Specify: COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY ndery (0-12) College (1-4 or 5+) LOAD a 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) e.Aux reorge UNKNOWN, BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 oise Maune 600 Baltimore Md. West North 20a, METHOD OF DISPOSITION

1 Burlel 2 Cremation 3 Removal from State
4 Donation 6 Other County 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION -- City or Town, Stata Donation 6 - Other (Specify) 4-7-93 Glen Bunnie, Md. Cem 21. SIGNATURE OF FUNERAL SERVICE LICENS 22. NAME AND ADDRESS OF FACILITY 638 N. Gilmor St. 21217 Albert Wulie-Mortician P. 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory strest, shock, or heart feiture. List only one ceuse on asch line. Approximate Interval Between IMMEDIATE CAUSE (Finel Onset and Death disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Cito seferatio cardio voscular dis care CERTIFICATION Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury OUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY Pressur ulcers 1 | YES 2 | 100 Chronic Obstructive Performing Diocesse 1 | YES 2 | NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

1 YES 2 MO 26. PLACE OF OEATH (Check only one) OTHER:
4 | Nursing Home | 5 | Residence | 6 | Other (Specify) npatient 2 - ER/Outpetlent 3 - DOA 27. MANNER OF OEATH 28a, DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending investigation BY 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 4 Homicide 29a. CERTIFIER 1 DEERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basia of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Mighth, Day, Year) BE 30. NAME AND ADDRESS OF PERSO COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print)

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31. DATE FILED (Month, Day, Year)

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93 09817 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Anthony D. Gaetano April 6:10 AM м 4 1993 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign 1 XX 2 | F YRS. 578-20-3329 Feb. 1924 5. New York 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH BC COUNTY OF DEATH DIRECTOR Greater Laurel Beltsville Hospital Laurel Prince George's RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's 1 YES 2 NO Laurel FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1016 7th Street 20707 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 KMever Married 2 Married IF YES, GIVE WAR OR DATES В Specify: 3 Widowed 4 Divorced 1942-1946 White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) 0 Customer Service Rep. Stone Company 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) Leonardo BE Gaetano Rose <u>Panabianco</u> 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Frances Gaetano 2384 Mitchellville Rd. Bowie, Maryland 20716 20e. METHOD OF DISPOSITION
1 M Buriel 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE Lincoln Cemetery 4-9-93 Brentwood, Maryland 21. SIGNATURE OF FUNERAL SERVICE LIGENSEE 22. NAME AND ADDRESS OF FACILITY Fort Lincoln Funeral Home, Inc., 3401 M00877 Bladensburg Rd., Brentwood, MD 23. PART 3. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, Approximate shock, or heart feliure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Finel Onset and Desth diseese or condition . Acute Exacerbation Chronic Obstructive Pulmonary Disease resulting in death) DUE TO (OR AS A CONSEQUENCE OF): L Acute Bronchitis CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If sny, leading to immediate cause. Enter UNDERLYING Congestive Heart Failure CAUSE (Disesse or injury that initiated events DUE TO (DR AS A CONSEQUENCE OF) resulting in death) LAST PART II. Other algoriticent conditions contributing to death but not resulting in the underlying ceuse given in Part i. PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY 1 YES 2 TO NO OF DEATH? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: ¼Xinpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 1 YES 2XX NO 4 Nursing Home 5 Residence 8 Other (Specify) 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 5 Pending Investigation 1 | XNatural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, streef, fectory, office building, stc. (Specify) 3 Suicide ETED. 8 Could not be 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined PASCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the filme, data and place, end due to the cause(s) end menner es stated. COMPL To MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERHFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) D12015 April 5, 1993 2 30. NAME AND ADDRESS OF PERSON

6492 Landover Road, Landover, Maryland

WHOLCOMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

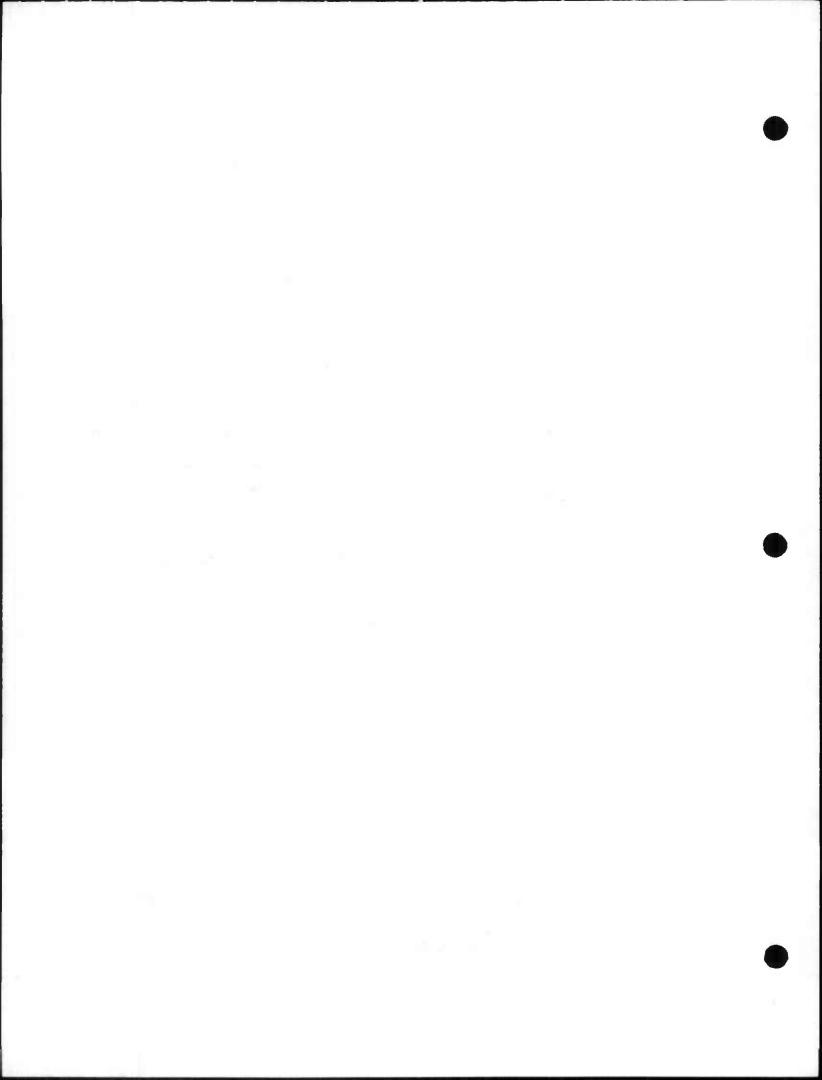
132. FIGISTRAR'S SAMETURE

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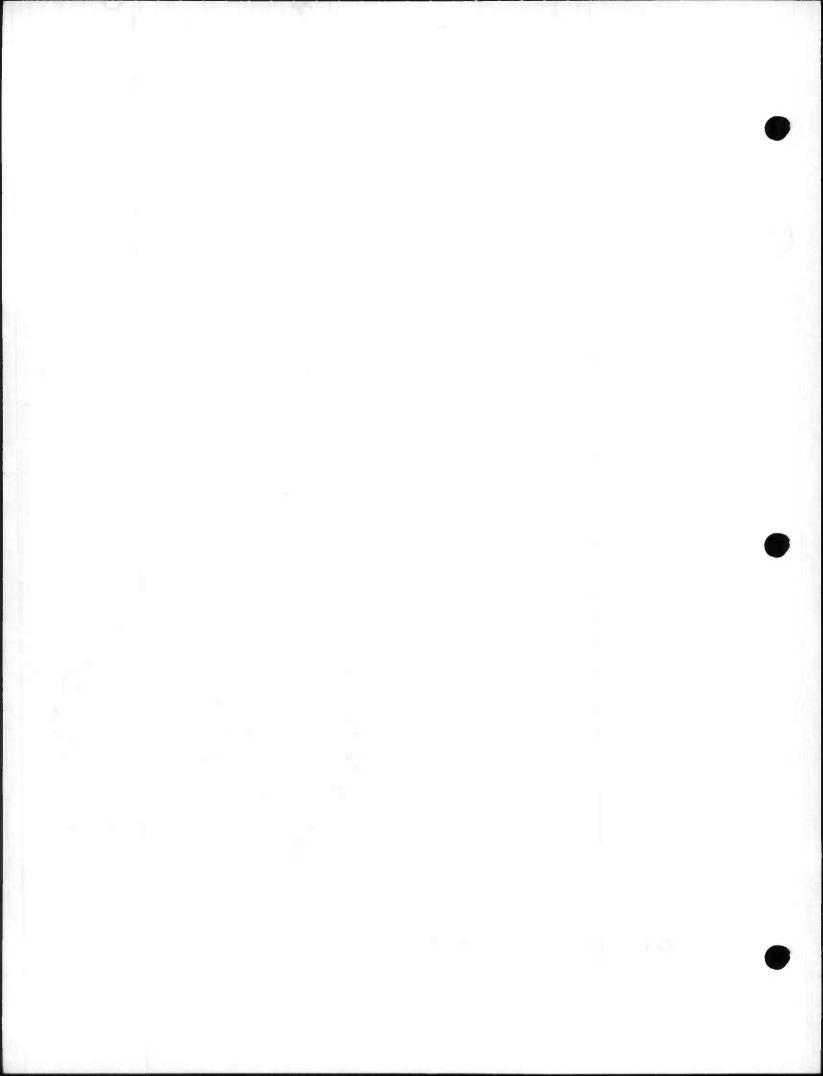
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	1 - STATE OF MARYLAND C			HEALTH AND F DEATH		HYGIEN REG. NO.	Ε		0 50 1	
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF	DEATH	v	YEAR 3	. TIME OF DEATH	
	NORMAN O.		GROV	'ER	04	05	199		6:10 PM	
	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. In $217-01-0769$	st birthday) YRS.	IF UNDER 1 YEA MONTHS DAY		(Month, D		6	Country)	ACE (State or Foreign	
e B	9a. FACILITY NAME (If not institution, give street and number) 6 WEST 23rd STREET.			MORE C			9c. COUI	NTY OF DEA		
ਹ	RESIDENCE OF DECEDENT  10a, STATE  10b, COUNTY	40 00								
DIRECTOR	MARYLAND	10c. CIT	TY, TOWN OR LO	LTIMORE	CIT	Y			10d. INSIDE CITY LIMITS?  XX YES 2 \( \square\) NO	
AAL	10e. STREET AND NUMBER					10g. CITI		AT COUNTRY?		
FUNERAL	6 WEST 23rd. STREET				218			U.S.	A.	
В	11. MARITAL STATUS 1 Never Married XX Married 3 Wildowed 4 Divorced  12. WAS DECEDENT EVER IN U.S. AI FORCES? XX YES 2 IF YES, GIVE WAR OR DATES WAR WORLD II		13. WAS ( If yes,	ECENDENT OF HISF specify Cuban, Mex ES X X NO Spe	'ANIC ORIGIN? (: ican, Puerto Rica cify:	Specify Yea in, etc.)	or No-	Specify:	American Indian, White, atc.	
ED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) (6	ECEDENT'S	USUAL OCCUP	TION	18b. KJ	ND OF BUS	SINESS/IND		TIB	
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+)  12 YEARS	. Do NOT u	work done during se retired.)  ANAGER		APAR	TMEN	VTS			
ш	17. FATHER'S NAME (First, Middle, Last) THOMAS HOLLINS GROV	ER			NNIE	tle, Maiden GAN	100			
TO B	19a. INFORMANT'S NAME (Type/Print)  FRANCES F. GROVER (WIFE)			rd. STR					21218	
	Magazinat 2 ☐ Cremation 3 ☐ Removal from State   cametery, or	AND DATE	OF DISPOSITION	Name of	OATE	20c. LO	CATION —	City or Town		
	4 Donation 5 Other (Specify) MORE  21. SIGNATURE OF FUNERAL SERVICE LICENSEE	LANI		ANO ADDRESS OF	4-9	DA	птт	TORE,	MD. 21234	
	P. S. Ruis	_	490	HENRY 5 YORK	W. JI ROAD,	BALT	O., M	$\mathbf{m}$ . 2	S 1212	
	23. PART I. Enter the disease, or complications that caused the disease or cause on each line  IMMEDIATE CAUSE (Fine) disease or condition resulting in death)  a. Due to (or as a const	<b>.</b>						eat,	Approximate Interval Between Onset and Death	
CERTIFICATION	disease or condition reaulting in death)  Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):									
PHYSICIAN: MEDICAL C	PART, II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I.  24s. WAS AN AUTOPSY PERFORMEO?  WITH YES 2 NO  24b. WERE AUTOPSY FINDINGS  AMILIABLE PRIOR TO  COMPLETION OF CAUSE OF DEATH?  1 XYES 2 NO									
MA	25. WAS CASE REFERRED TO MEDICAL		26.	PLACE OF OEATH (	Check only one)					
Sic	EXAMINER?  HOSPITAL:  1   topatient 2   ER/Outpatient 3	DOA DOA	OTHER.	ome XXResidence		pecify)				
ВУ РНУ	27. MANNER OF DEATH  1 \(\bigcap \) Natural 5 \(\bigcap \) Pending 2 \(\bigcap \) Accident investigation \(\bigcap \) 4 \(\bigcap \) 0 5 \(\bigcap \) 9 3	28b. TIM INJ 6:0	E OF 28c.	NJURY AT VORK? YES 2 XNO	28d. DESCR	BE HOW IN			LF.	
	Suicide 6 Could not be building, etc. (Specify)		street, tactory, of	fice		281. LOCATION (Street and Number or Purel Poute Number, City or Town, State) 6 WEST 23rd STREET.				
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, do not not not not not not not not not no	ath occurre	ed at the time, d	rte and place, and de	e to the cause(	e) and man	ner as state	ed.		
	296. SIGNATURE AND TITLE OF CERTIFIER	4.2.43	, -,-,-,-			proven and				
TO BE	An Dan			O.C.M					onth, Day, Year) 1993	
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	31. DATE FILEO (Month, Day, Year)  APR = 1993	Me.	Ti.							

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page he study within 20 hours after death with the State Dent of Health and Mental Hydiene prior to hard, cremitation or removal	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be
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		FOR 1 - STATE REGISTRAR	STATE OF MA			TMENT O			MENTA	L HYGIEN	_	20	0901
	1	1. DECEDENT'S NAME (First, Middle, Last)  MABEL E	HIGH						2. DATE MONT	OF DEATH	NY.	YEAR 3.	TIME OF DEATH
	1	4. SOCIAL SECURITY NUMBER		3. AGE (In yrs. les	st birthday)	IF UNDER 1 YE		ER 24 HRS.	7. DATE	OF BIRTH h, Day, Year)			CE (State or Foreign
		00 21/011	1   M 2X X)F	88	YRS.				5/:	1/1904	4		yland
0,0		9e. FACILITY NAME (If not institution, give stre				9b. CITY, TO	/N OR LOCAT	TION OF DI	EATH		9c. COUN	TY OF DEATI	Н
Į.		332 EAST 20th	STREET			BALT	IMOR	E					
DIRECTOR		10a, STATE 10b. COUNTY			10c. CIT	Ral+	imore	2					I. INSIDE CITY LIMITS? YES 2 NO
	- 1	10a. STREET AND NUMBER			1	Dait	101. ZIP CO				10g. CITIZ	- 41	COUNTRY?
EB		1720 N. FULTO	N AVE				21:	217				USA	
BY FUNERAL		11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 [ IF YES, GIVE WA	YES 2 X		If yes	DECENDENT specify Cub YES 2X NO	en, Mexica	in, Puerto	17 (Specify Yes Rican, etc.)	or No-		American Indian.
0		15. OECEDENT'S EDUCA		16a. DE	CEDENT'S	USUAL OCCU	ATION	-	168	. KIND OF BUS	SINESS/INDU	ISTRY	22:101
COMPLET		(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 6+)	(G iiie		vork done during the retired.) HOMEM		iding					
		17. FATHER'S NAME (First, Middle, Last)					18. MO	THER'S NA	ME (First,	Middle, Malden	Surneme)		
BEC	- 41	ELLISLE YOU	NG				7	JIOL	А НІ	ENDERS	SON		2
TO		190. INFORMANT'S NAME (Type/Print) FORSTER A. HIGH		19						ber, City or Town			
								ST P	ARK				D. 21207
167		294 METHOD OF DISPOSITION 412 Burlel 2 Cremation 3 Remov	ral from State	cemetery, cre		OF DISPOSITION  (ther place)	(Name of		DAT	E 20c. LO	CATION C	lty or Town,	State
		4 Donation 6 Other (Specify)	NSEE	I MT	ZIO		E AND ADDR	ESS OF FA	CILITY	BAI	LTO,	CO.	MD.
a cycle	j	Joseph L.	Russ			JOS		. R	USS	FUNEI			MD.21216
200		23. PORT I. Enter me diseases, or co ahock, or heart fallure. Li	mplications that	caused the de	ath. Do n	ot enter the	mode of d	ylng, suc	h es can	diac or respi	ratory arre	st,	Approximate
		IMMEDIATE CAUSE (Final disease or condition resulting in death)	C			re He	ear	e F	ai	lus q 8Cerl			Interval Between Onset and Death
	Í	a.	DUE TO (C	R AS A CONSE	OUENCE OF	7):	(-	2 . 0 .	006	00.1	200	20 01	
Z		Sequentially list conditions, b.	Age				100	all		scene	CC Su	asog	
A		If any, leading to immediate cause, Enter UNDERLYING	Ply	AS A CONSE	AA.O D	000						6.0	
FIG		CAUSE (Disease or Injury thet initiated events	DUE TO	AS A CONSE	QUENCE OF	7:							
CERTIFICATION		resulting in desth) LAST											
Ö		PART II. Other algolificent conditions	contributing to d	eeth but not r	maulting i	n the under	dog ceuse	alven In	Part I	24- MBC AN	AITTOREY	245 905	RE AUTOPSY FINDINGS
. S		au	rema				,,			PERFOR	MED?	AWA	ALABLE PRIOR TO WPLETION OF CAUSE
MEDICA		ne	rema	wert	4'PAG	ine	21			1 TYES 2	□ NO		DEATH?
2					104	70	1		_			1	] 7ES 2 [] NO
PHYSICIAN:		25. WAS CASE REFERRED TO MEDICAL EXAMINER?					PLACE OF	DEATH (Ch	eck only o	ne)			
YSI		1 PYES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER: 4   Nursing	iome 5 🗆 F	Residence	8 🗆 Othe	er (Specify)			6
<	- 100	27. MANNER OF DEATH  1 Natural 5 Pending	28e. DATE OF III (Month, Day	JURY Year)	28b. TIM	URY	INJURY AT WORK?		28d. DE	CRIBE HOW I	NJURY OCCI	IRED	
8		2 Accident Investigation	28a PLACE OF	IN.IIJBY — At bo	me ferm s		YES 2	∐ NO	204 1 00	ATION (Comment	and At his hours	0-10-1	01
building, etc. (Specify)  Lifty or Town, State)									Number,				
COMPLET		29e. CERTIFIER (Check only 1 CERTIFYING PHYSICI.	AN: To the heat of m	v knowledne de	ath occur	od at the time	fitte and also	n and 4	to the s	mo(a) and	21 220	/	
. MP		(Check only one) 2 MEDICAL EXAMINER:											d manner as stated.
E CO	- 11	29b. SIGNATURE AND TITLE OF CERTIFIER	4	-				CENSE NUI					rith, Day, Year)
2 0		duel Ul	beroll				1)8	267.	48		14	1619	3
<b> </b>   2		30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF DEATH (ITE	M 27) (Time	Drint)	-		0	-	1	0 (	

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
PNIL (BERUE, 3834 FALLS PD)

BALTOMD2121/

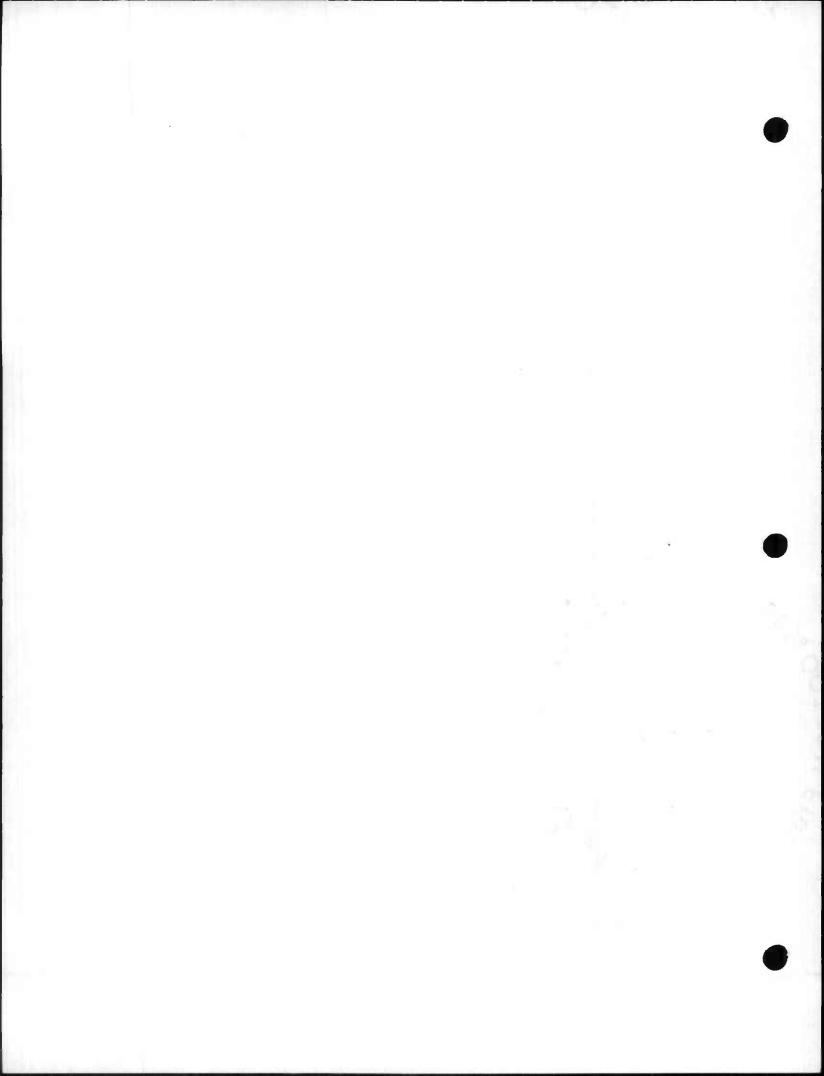


DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	10 FME FUNDEAL UNDERFORD SET THE STATE OF THE STATE OF THE ALTERIAL PROPERTY AND A THE NUMBER OF THE DESCRIPTION OF THE DESCRIPTION OF THE OFFICE OF THE OFFICE OF THE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFI	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	HEGISTRAH			CHIIL	ICALE	JE DEATH		REG. NO.				
à	1. DECEDENT'S NAME (First, Middle, Last)  JOHN BURGESS H	ENRY						2. DATE OF DEATH DAY YEAR 3. TIME OF DEATH			TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (V/ yrs. 10	net historiani)	IF UNDER 1 Y	EAR IF UNDER 24 HRS.	7 0477	OF BIRTH	_	93	-	
	215-20-8577	1 🔀 M 2 🗆 F	8.			AYS HOURS MIN.	(Mon	h, Day, Year)	8. BIRTHPLACE (State or Foreign Country) HANCOCK, MD.			
	9a. FACILITY NAME (If not institution, give :		96. CITY, TO	WN OR LOCATION OF				NTY OF DEA				
OR	CHARLESTOWN CARE	CENTER				BALTIMORE				BAL	TIMORE	
5	RESIDENCE OF DECEDENT											
DIRECTOR	10a. STATE 10b. COUNT			10c. CIT	Y, TOWN OR L					-1	Od. INSIDE CITY LIMITS?	
	MARYLAND ANNE	ARUNDEL			SEVER	NA PARK					YES 2 NO	
RA	Tellings and street					101. ZIP CODE					AT COUNTRY?	
FUNERAL	734 BENFIELD ROAD	12. WAS DECEDENT			I	211				.S.A.		
	1 Never Married 2 Married	FORCES? 1	YES 2X	NO	If ye	DECENDENT OF HISP a, specify Cuban, Mexi	can, Puerto	N? (Specify Yes Rican, etc.)	or No-	14. RACE - Black, 1	- American Indian, White, etc.	
B	3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES		10	YES 2 X NO Spec	cify:			Specify:	WHITE	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade		16a. D	ECEDENT'S	USUAL OCCU	PATION	160	. KINO OF BUS	BINESS/INC	DUSTRY		
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	) //			g most of working						
P P		4 YRS		PERS	ONNEL	MANAGER	MD	UNEMP	LOYM	ENT S	ECURITY	
	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S						
H	EDGAR HENRY			_		MARY H						
٩	19a. INFORMANT'S NAME (Type/Print)	NOTON	1			reet and Number or Run						
	MEREDITH L. WARRI	NGTON	100 0000			LD ROAD -						
	1 Donation 6 Other (Specify)	noval from State			OF DISPOSITION OF DIS	N (Name of	4/7				City or Town, State	
	21. SIGNATURE OF FUHICIUM SERVICE LI	CENSEE	THE I'M	J. KIEI		E AND ADDRESS OF	1.7	] DA	LTIM	OKE	-	
	· ( Unt.	1 4	Treat			BARD FUNE				DE M	01000	
	23. PART   Enter the disesses or	compilertions that	caused the d	leath Do r	ot enter the	7 WILKENS	AVEN	UE-BAL	T IMU!	KE, MI	Approximate	
	snock, or nesrt failure.	List only one caut	e on each lin	10.	ot enter the	mode of dying, se	ICH WE CHI	orac or respi	retory sri	rest,	interval Between	
	IMMEDIATE CAUSE (Finel disease or condition											
	resulting in death) s. Devigoration  OUE TO (OR AS A CONSEQUENCE OF):											
z	- Dementia											
CERTIFICATION	Sequentially list conditions, if any, leading to immediate  DUE TO (OR AS A CONSEQUENCE OF):											
S	CAUSE (Disease or Injury	c										
E	that initiated events resulting in death) LAST	DUE TO (	OR AS A CONSE	EQUENCE OF	7):							
5		d		-								
	PART II. Other significent condition	ns contributing to	death but not	resulting	n the under	iying cause given i	n Part i.	24s. WAS AN			PERE AUTOPSY FINDINGS	
EDICAL								PERFOR		C	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
ME											YES 2 NO	
ä												
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:				6. PLACE OF DEATH (	Check only o	ne)				
YSI	1 TES 2 NO	1 Inpatient 2 I	ER/Outpatient	3 🗆 DOA	OTHER:	Home 5 - Residence	6 🗆 Othi	er (Specify)				
	27. MANNER OF DEATH  1 Pointing 5 Pending	28s. DATE OF ( (Month, Da		28b. TIM	URY	WORK?	28d. DE	SCRIBE HOW I	NJURY OC	CURED		
B	2 Accident Investigation	00 PL 405 05				YES 2 NO						
ED	3 Suicide 6 Could not be 4 Homicide determined	building, e	FINJURY — At h Mc. (Specify)	oms, farm, s	treet, factory,	offics	281. LOC City	ATION (Street of Town, State)	ind Number	or Rural Rou	ite Number,	
	29a. CERTIFIER						1	_				
COMPLETED	(Check only one)  200 CERTIFYING PHYS  C										and manner as stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIE					29c. LICENSE N					fonth, Day, Year)	
) BE	Syr	an					アフ		D 4/	/ /	93	
2	30. NAME AND ADDRESS OF PERSON WH									, ,	1	
	Gany Apple	baum my	7/11	maria	les ch	orce Lagr	21	228				
į	31. DATE FILED (MONTH, Day, Your) APR 07 1993	32. REGISTRAF	SIGNATURE	1.00								
	1100 II / IYY (	france way	1000n-1101	Den								



	FOR 1 • STATE REGISTRAR	STATE OF M	ARYLAND /	DEPAR ERTIF	TMENT	OF H	EALTH DEA	AND	MENT		YGIEN		93	09821
	1. DECEDENT'S NAME (First, Middle, Last)							2. DAT	E OF D	EATH			3. TIME OF DEATH	
	JOHN	EDV	VARD			HI.	AFKA		0.4		04	AY 1.Q	YEAR	4:00 P M
	4. SOCIAL SECURITY NUMBER	- T	6. AGE (In yrs. les	t birthday)	IF UNDER		IF UNDER	_	7. DAT	E OF BI	RTH	1.9		PLACE (State or Foreign
ĺ	218-74-9144	1 💢 M 2 🗆 F	24	YRS.	MONTHS	DAYS	HOURS	MIN.	Feb	nth, Day,	_	1969	Country	ryland
	9a. FACILITY NAME (If not institution, give stre	set and number)	0.00		9b. CITY,	TOWN C	R LOCATI	ON OF D		' e	12		NTY OF D	
8	ST. AGNES HOSE	ΤͲΛΤ			ו גם	ייי דו	/ODE	CT	m 57					
DIRECTOR	ST. AGNES HOSPITAL BALTIMORE CITY.													
뿐	Md. Balt:		10c. CIT	Y, TOWN O	R LOCAT	ION							10d. INSIDE CITY LIMITS?	
												1 YES 2 NO		
RAL	10e. STREET AND NUMBER					101	. ZIP COD					10g. CIT	ZEN OF W	NAT COUNTRY?
FUNE	924 Leeds Avenue						2122						JSA	
5	11. MARITAL STATUS  1 Never Married 2 Merried	12. WAS DECEDENT FORCES? 1 [	EVER IN U.S. AR	MED 10	13. 1	MAS DEC	ENDENT C	OF HISPAI	NIC ORIG	IN? (Sp	etc.)	or No-	14. RACE Black	- American Indian, White, atc.
₽	3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES				2 <b>N</b> NO			a rinees			Specif	ly:
0	15. DECEDENT'S EDUCA	ATION	16a DE	CEDENT'S	USUAL OC	CHIDATIC	MA .		152	A MINIO	05.00	SINESS/IND		white
<u> </u>	(Specify only highest grade c	ompleted) College (1-4 or 5 +)	(G		work done o			ng	1 "	ND. KINL	OF BU	SINCSS/INL	JUSTRY	
립	12	College (1-4 of 5 +)		Jarek	ouse	Wor	rker							
at once.	17. FATHER'S NAME (First, Middle, Last)							HER'S NA	ME (First	Middle	Maiden	Surneme)	_	
111 B	Walter R. Mayo							ther						
B C	19a. INFORMANT'S NAME (Type/Print)		198	b. MAILING	ADDRESS	(Street a				111		n, State, Zip	Code)	
De notified TO BI	Katherine A. Phil.	lips	1	1166	Wash	Washington Blvd., Balto., Md. 21230								
-	20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remove	ral from State	20b. PLACE			TION (Ne	me of		DA	TE	20c. LO	CATION -	City or Tox	wn, State
Ē	New Cathedral Cemetery 4/08 Reltimore, Maryland												Maryland	
examiner must	21. SIGNATURE OF SUMMAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  Gary L. Kaufman Funeral Homes													
8	5695 Main St., Elkridge, Md. 21227													
event, the medical	22. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or reapiratory arrest, shock, or heart tellure. List only one cause on each line.  Approximate interval Between Onset and Death disease or condition resulting in death)													
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):													
MEDICAL	PART II. Other aignificent conditions	contributing to d	leeth but not r	eauiting i	n the un	deriying	cause (	given in	Part i.		WAS AN PERFOR	MED?		WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
A Z	25. WAS CASE REFERRED TO MEDICAL					28. Pl	ACE OF D	EATH /Ch	eck anlv a	ne)				
		HOSPITAL:	ER/Outpetient 2		OTHER	:								
0 >	27. MANNER OF DEATH	28e. DATE OF II	NJURY	28b. TIM	4 - Nurs	ing Home 28c. INJL		sidence				NJURY OCC	71050	
	1 Netural 5 Pending	04/04	/93	208	HEV	WOI	RK?	NO.				HAN		SELF
	2 Accident Investigation 3 Suicide Could get be	26e, PLACE OF	INJURY — At hor	me ferm s				-						oute Number.
00 III	4 Homicide B Could not be determined	NCE		,			9 2%	or Tow	F. F.	S A'	VE.	oute Harriosi,		
	290. CERTIFIER 1 CERTIFYING PHYSICI					_					_			
MPORTANT: If Item  O BE COMPLE	(Check only one)  1 CERTIFYING PHYSICI  2 MEDICAL EXAMINER:	On the basis of exa	my knowledge, dea	nth occurre	n, in my op	ne, date oinion, de	end place, eath occur	end due	to the ce time, dat	e end p	end mar lace, en	ner ee stat d due to th	ed. e cause(e)	end menner as stated.
PORTA BE C	29b. SIGNATURE AND TITLE OF CENTIFIER	) ~					29c. LICE	NSE NUN	IBER			29d. DAT	E SIGNED	(Month, Day, Year)
F O	m	-(X)					0.	C.M	Ε.			▶ 0	4/05	/1993
F	30. NAME AND ADDRESS OF PERSON WHO		111 Pe			et,	Ва	ltir	nore	е,	Maı			21201
	APR 07 1993 July	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE												

Junion A

020	physician.
<b>1LTIMORE, MARYLAND 21215-0020</b>	or attending
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ND 2	by the hospital
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MAR	retained
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Σ	Page
1	eath.

BALT	death.
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	hours
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50,	within
( 687	executed
2	2
.O. B(	certificate
ď.	death
Ö	the
Ä	hat
RECC	requires
_	AM.
Z	The
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death,
VISION	ATTENDING
3	OR

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1 -1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Wiltiam YEAR Holland 4 6 1993 12:27 A M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 11-20-21 IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS DAYS HOURS 156-07-5864 1 X X 2 - F YRS filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Mercy Hospital Baltimore 16c. CITY, TOWN OR LOCATION Baltimore 10e. STATE 10h COUNTY 10d. INSIDE CITY LIMITS? Md. 1 STES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 611 South Charles Btreet 21230 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 PYES 2 NO Specify: 14. RACE — American Indian, Black, White, alc. Specify: Black 1 Never Married 2 Married BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple Elementary/Secondary (0-12) College (1-4 or 5+) Unk. 6 th17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Unk. Unk BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Eloise Mayne 600 West North Ave. Baltimore, Md. pe 20a. HETHOD OF DISPOSITION

1 Burial 2 Cremation 3 Re

4 Donation 5 Other (Specify) 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must Calvary Cem. \$ 4-8-93 Glen Burnie, Md. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY 638 N. Gilmor St. 21217 Wulie-Mortician Albert P medical 23. PART I. Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feliure. Let only one couse on each line. Approximata Interval Between 0 **IMMEDIATE CAUSE (Fine) Onset and Death** cremation, traumatic event, the disease or condition DUE TO (OR AS CONSEQUENCE OF): 3days signed by the attending physician and completely Health and Mental Hygiene prior to burial, crematic resulting in death) CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events other DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST 6 shows any Injury, PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMED? 1 TES 2 NO OF DEATH? 1 TYES 2 NO certificate has been in the State Dept. of PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL:
1) Unpatient 2 - ER/Outpatient 3 - DOA **EXAMINER?** OTHER: 1 TES 2 NO 4 - Nurs e 5 ☐ Residence 8 ☐ Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED FUNERAL DIRECTOR: After this o within 72 hours after death with Is marked, 1 Natural 1 YES 2 NO BY 2 Accident 28a. PLACE OF INJURY — At home, larm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be COMPLETED Item 28 4 Homicide 29e. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) and menner as stated. TO THE HOSPITAL OF TO THE FUNERAL DE BIED WITHIN 72 ho 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Jellopen W Medical Desident

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 9

Mercy Hospital

Jan Jandest Handell

Raltimae

mol

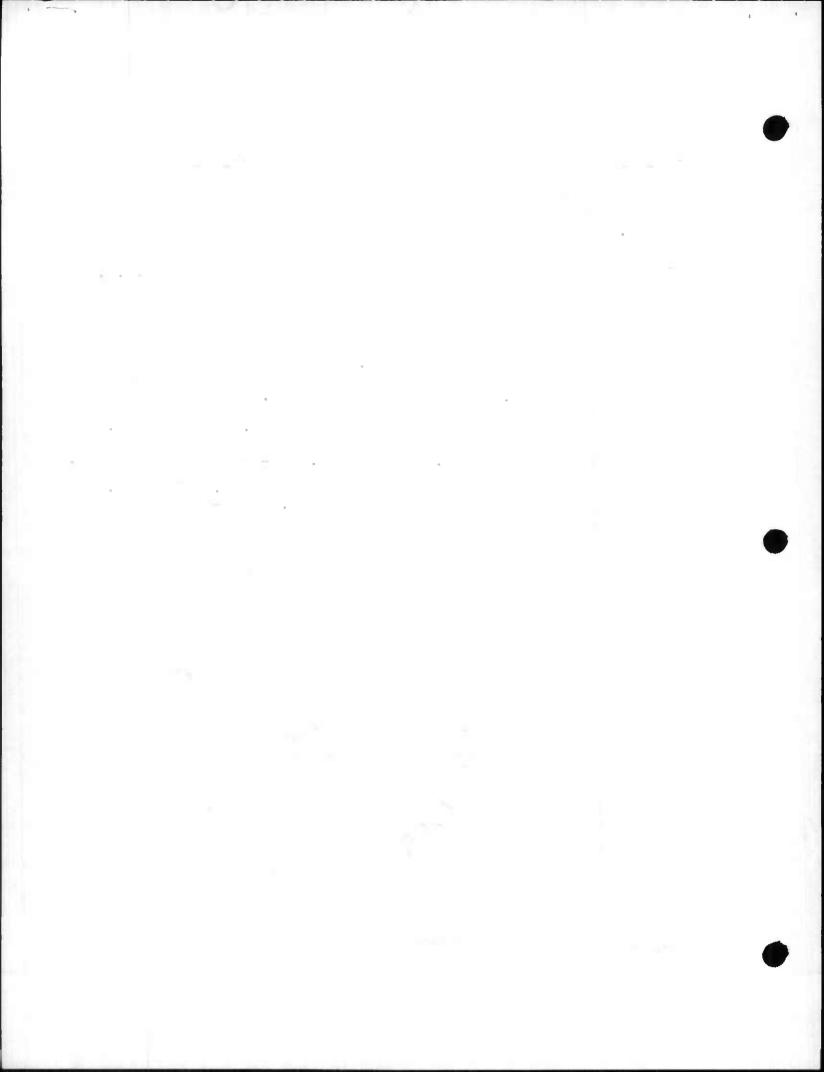
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1993

31. DATE TILED (Month.



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	1.	DE	CE	DEI	YT	3	N

	1 - STATE REGISTRAR	INIE UP MANTLA		ICATE OF	DEATH	MENIAL HYGIEN REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)		3. TIME OF DEATN						
	SARAH MARIE	HAMMONI	)			April 6 1	993	10 A M	
	4. SOCIAL SECURITY NUMBER 5. S		n yrs. last birthday) .	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTN		BIRTHPLACE (State or Foreign	
	217-56-2225	M 2 √ F 92	YRS.	MONTHS DAYS	HOURS MIN.	(Morth, Day, Year) May 14, 19	100 F	Balto. Co. Md.	
	an. FACILITY NAME (If not institution, give street ar	nd number)		9b. CITY, TOWN	OR LOCATION OF DE		9c. COUNTY		
8	Washington Co Go	eneral Hasy	rital	Нас	erstown		6	Vashington Co.	
티	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNTY								
DIRECTOR	Md. Washin	natan		v, town or Loca Boones bo				10d. INSIDE CITY LIMITS?	
	10e. STREET AND NUMBER	igion			ZIP CODE			1 YES 2 NO	
R A	Rt 2 Fahmey Keedy N	lamarial Ho	imo	10	21713		10g. CITIZEI	USA	
FUNERAL		MAS DECEDENT EVER IN		40 1110 050					
	1 Never Married 2 Married F	FORCES? 1 YES	2 1/ MO	If yes, sp	ecify Cuban, Maxicar	HC ORIGIN? (Specify Yearn, Puerto Rican, etc.)	or No- 14	. RACE — American Indian, Black, Whita, etc.	
B≺	3√√ Widowed 4 □ Divorced	F YES, GIVE WAR OR DA	TES	1 TYES	2 NO Specify	**		Specify: White	
8	15. DECEDENT'S EDUCATION	N.	16a. DECEDENT'S	USUAL OCCUPATION	ON:	16b. KIND OF BU	SINESS/INDUS		
E	(Specify only highest grade completing (Secondary (0-12) Coll	lege (1-4 pr 5+)	(Give kind of a life. Do NOT us	work done during mo se retired.)	st of working	ľ			
AP.	High School		Но	usewife					
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAI	ME (First, Middle, Malden	Surname)		
BE	Edward Bollinger				Elma	Foster			
2	19a. INFORMANT'S NAME (Type/Print)				nd Number or Rural R	loute Number, City or Tow			
-	Mr. Gregory E. Hammo	nd	2761	Rugby Av	e. Syke	sville, Ma	. 2178	34	
	20a. METHOD OF DISPOSITION  XX Burial 2 □ Cremation 3 □ Ramoval fr	rom Stata 20b.	PLACE AND DATE	OF DISPOSITION (Na	me of	DATE 20c. LO		AT PERSON AS A STATE OF THE STA	
	4 Donation 5 Other (Specify)	11	orraine	Park Ce	metery				
- 1	The strange of Funesia, service oceases	0/.			ID ADDRESS OF FAC	1187	4 Reis	terstown Rd.	
	Janu C	Nem		Eline	Funeral	Home Reis	tersto	wn, Md. 21136	
	23. PART i. Enter the diseases, or compleshock, or heart feliure. List of	lications that coused	the deeth. Do r	not enter the mo	de of dying, such	as cerdiec or respi	retory arrea	, Approximete	
	IMMEDIATE CALISE /Final				1			interval Between Onset and Death	
	disease or condition	ardiopy Due to 10 A AS A Theros	Imong	ITU, a	rrest				
	,	DUE TO (OR AS A	CONSEQUENCE OF	F): /	1	ſ	1.		
S	Sequentially list conditions.	theros	clerot	ic c	ard 10	U95C4/ai	915	ease	
Ě	if any, leeding to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF	7):					
S	CAUSE (Diseese or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	٦.					
CERTIFICATION	resulting in death) LAST			,				İ	
빙	0								
ICAL	PART II. Other significent conditions con		it not reculting i	n the underlying	ceuse given in I	Part i. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
ă	Renal tail	ure				1 YES 2	□ NO	COMPLETION OF CAUSE OF DEATH?	
M						_   '		1 🗌 YES 2 🗌 NO	
ä									
₫	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	SPITAL:		26. PL	ACE OF DEATH (Che	ck only one)			
PHYSICIAN: MED	1 VES 3 NO J Inpetiant 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify)  27. MANNER OF DEATN  28s. DATE OF INJURY  28b. TIME OF 28s. IM HIST AT 28s. DESCRIPE HOW INJURY CONVERN.								
	Netural 5 Pending	(Month, Day, Year)	28b. TIMI INJ	URY WO	RK?	28d. DEŞCRIBE HOW II	NJURY OCCUR	ED	
à I	2 Accident Investigation	28. DI ACE OF IN IMPV	41.5	M 1 🗆 1					
	3 Suicide e Could not be 4 Homicide detarmined	28a. PLACE OF INJURY - building, etc. (Specif	y)	Rreel, factory, offic	'	28f. LOCATION (Street a City or Town, State)	nd Number or i	Rural Route Number,	
COMPLETED	29a. CERTIFIER								
MP	(Check only								
8	2 MEDICAL EXAMINER: On I	The Deals of examination	and/or investigatio	n, in my opinion, d	eath occured at the I	lime, data and placa, an	d due to the co	ause(a) and manner as stated.	
띪	296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. DATE SIGNED (Name, Day, Year)								
2	TO GE THU		RM.		D175	9	P 4/	6/93	
	30NAME AND ADDRESS OF PERSON WHO COM	PLETED CAUSE OF DEA	тн (ITEM 27) ( <i>Typ</i> e,	Print)					
1	31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIGNA	Time						
5	APR - 7 1993 A	. K	Lant 1	₹					

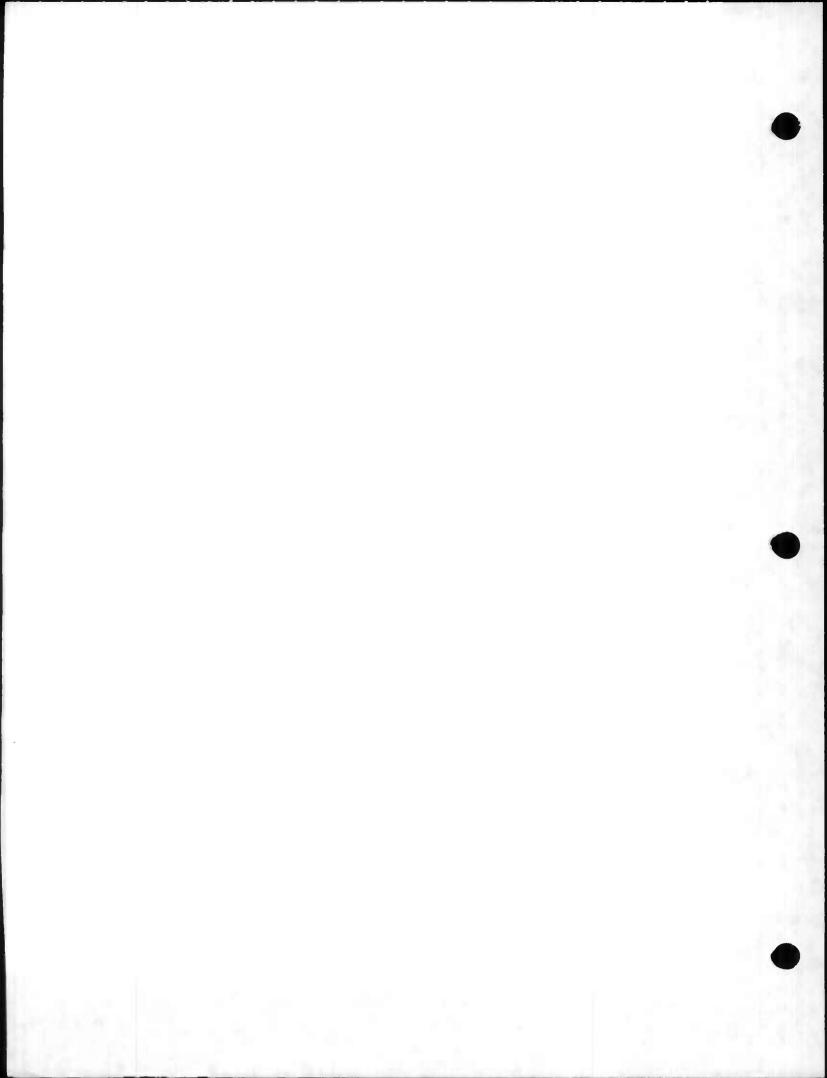
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trope filed within 72 hours after death with the State Dept. of Heatth and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

DHMH-16 Rev 1/89

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

1. DECEDENT	S NAME (First, Middle, Last)	7.	11 6 .						2. DATE	OF DEATH		3.	TIME OF DEATH
Irene Hunter							04	04 06 93 1:30 a					
	CURITY NUMBER	5. SEX	6. AGE (In yrs. I		IF UNDER	DAYS	IF UNDE	MIN.	(Month	OF BIRTH Day, Year)		6. BIRTHPLACE (State or Foreign Country)	
	2-1455	1 🗆 M 2 💭 F	93	YRS.				52.111		/01/18		PA	
(	NAME (If not institution, give s	1			200			ION OF DE	ATH			Y OF DEAT	
Chape	L HILL CONL	ial. Home			Ran	dal	lstou	<i>yn</i>			Balt	imore	co.
10a. STATE	10b. COUNT	Υ		10c. CIT	Y, TOWN	OR LOCA	TION					100	I. INSIDE CITY LIMITS?
MD	Balt	timore Co	•	Tou	son							1 [	YES 2 ND
10e. STREET						10f. ZIP CODE 10g. CITIZEN OF WHAT						COUNTRY?	
	Rd.					$\perp$	2120				USA		
11. MARITAL S	TATUS arried 2 Married		YES 2 X			If yes, s	pecify Cub	an, Maxicai	n, Puarlo R	? (Specify Yea lican, etc.)	or No 1	4. RACE — Black, W	American Indian, hita, etc.
10,00	4 Divorced	IF YES, GIVE	MAR OR DATES			1   YE	8 2 💢 ND	Specify	*			Specity:	
	15. DECEOENT'S EDU		16a, [	ECEDENT'S	USUAL O	CCUPAT	IDN		16b.	KINO OF BUS	SINESS/INDU	STRY	
Elementar	(Specify only highest grade r/Secondary (0-12)	College (1-4 or 5	+)	Give kind of te. Do NOT u	se retired.)	auring m	iost of work	ng					
8			H	lousek	eepe	オ							
17. FATHER'S	NAME (First, Middle, Last)			_		_	1			fiddle, Maiden	Surname)		
Ge	orge W. Hunt	ter						se u					
	NT'S NAME (Type/Print)		1							er, City or Tow			
	len H. Perri	1						Balt		e, MD			
1) Burial	OF DISPOSITION 2 Cremetion 3 Rem	novat from State		E AND DATE				10102	OATE		CATION — CI		
	5 Other (Specify)	CENCEE	from State competery, crematory or other place)  Drund Ridge Cem. 4/8/9  EE 22. NAME AND ADDRESS OF F							PLRE	esvill	e, mi	
TRing Funghal Home 11824 Rei							ster	town Rd					
1	Eline Funeral Home Reisterstown, MD 2113									MD 21136			
23. PART I.	Enter the diseases, or shock, or heart failure.				not ente	r the m	oda of d	ing, suci	h as card	iac or respi	ratory arres	ıt,	Approximate Interval Between
	CAUSE (Final		will.										Onset and Death
disease or resulting in			to CH										
			DUE TO (DR AS A CONSEDUENCE OF):										
	y list conditions,	b. HPS	(OR AS A CONS	EDUENCE D	e.								
	ing to immediata or UNDERLYING		enla										
CAUSE (Dis	ease or Injury	C	(OR AS A CONS	EQUENCE D	F):								
	death) LAST	4											
			3.1=x1.	7								_	
PART II. OT	har algnificant condition	na contributing to	deeth but not	resulting	in tha u	nderlylr	ng cause	given in	Part I.	24a. WAS AN PERFOR		AM	RE AUTOPSY FINDINGS MLABLE PRIOR TO
	HIR								-	1 TYES 2	TIME		MPLETION OF CAUSE DEATH?
		<del></del>										1 [	YES 2 ND
25 1400 0400	REFERRED TO MEDICAL						W ACE OF	DEATH OF	and and				
EXAMINE		HOSPITAL:	- EDIOUS	2 7 224	ОТНЕ	R:		DEATH (Ch					
27. MANNER		1 Inpetient 2		28b. T/A	IE OF		me 5 □ F	esidence		(Specify)	NJURY OCCU	RED	
1 Netural 5 Pending (Month, Day, Year) INJURY WORK?													
2 Accid	4.	28e. PLACE	28e. PLACE OF INJURY — At home, tarm, street, factory, office building, etc. (Specify)  28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)						281, LOCATION (Street and Number or Rural Route Number,				
4 Hom	e Coold not be	building											
29a. CERTIFIE		ICIAN: To the heat o	f my knowledge	death occur	ad at the	time de	a and also	a and dir	to the ar-	sals) and	nner en et-t-	-	
(Check or one)	2 MEDICAL EXAMIN												d manner as stated
29h Barangia	RE AND TITLE OF CERTIFIE			/				ENSE NU					
H Tarry managery	THE PARTY NAMED IN COLUMN TO		SICIA					ENSE NUN			290, DATE	SIGNED (MO	onth, Day, Year)



3. TIME OF DEATH

10d. INSIDE CITY

14. RACE — American Indian,

1 TES 2 X NO

White

Approximete

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE

1 TYES 2 T NO

or Rural Route Number

29d, DATE SIGNED (Month, Day,

intervai Between

**Onset and Death** 

8. BIRTHPLACE (State or Foreign

Virginia

12:20 PM

YEAR

9c. COUNTY OF DEATH

PRINCE GEORG'S

10g. CITIZEN OF WHAT COUNTRY?

United States

93

2. DATE OF DEATH DAY

7. DATE OF BIRTH

03

IF UNDER 24 HRS.

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

07 1993

4. SOCIAL SECURITY NUMBER

CORA L. HICKS

5. SEX

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228-16-6827 1 🗌 M 2 🖄 F 70 1/20/23 permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR GEORGE'S HOSPITAL CENTER Cheverly 10c. CITY, TOWN OR LOCATION Maryland Prince George's Landover FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 4100 Fairfax St. 20784 for use as the burial-transit 24 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 KYES 2 NO WAS DECEMDENT OF HISPANIC ORIGIN? (Specify Yes or Noif yes, specify Cuben, Mexican, Puerto Rican, etc.)
 \( \subseteq \text{YES} \) NO Specify: 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced WW II COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Bakery/Food Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12 detached Sales Clerk at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) and completely filled in by the funeral director, page 5 should be burial, cremation, or removal. Louis Walden Annie Mae Powell notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 8515 Oglethorpe St. New Carrollton, Md. 20784 <u>June Weckesser</u> 9 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must Lincoln Cemetery 4/5/93 Brentwood, Maryland ort examiner 21. SIGNATURE OF FUNERIAL SERVICE 22. NAME AND ADDRESS OF FACILITY Fort Lincoln Funeral Home, Inc. 3401 Bladensburg Rd. Brentwood, medical 23. PART i. Enter the ises, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. hronic IMMEDIATE CAUSE (Final traumatic event, the disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): signed by the attending physician at Health and Mental Hygiene prior to I if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? YES 2 NO this certificate has been with the State Dept. of 1 PHYSICIAN: 23 25. WAS CASE REFERRED-TO MEDICAL HOSPITAL: 26. PLACE OF DEATH (Check only one) **EXAMINER?** OTHER: 1 YES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 6 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED FUNERAL DIRECTOR: After this c within 72 hours after death with 1 Natural 1 YES 2 NO BY 2 Accident HOSPITAL OR ATTENDING 281. LOCATION (Street 28e. PLACE OF INJURY -3 Suicide 8 Could not be COMPLETED Item 28 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) TO THE HOSPITAL (
TO THE FUNERAL D
DE filed within 72 h
IMPORTANT: If It 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date and place, end due to the cause(e) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE m esance 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GERARDO 6510 KENILWORTH 31. DATE FILED (Month, Day, Year)

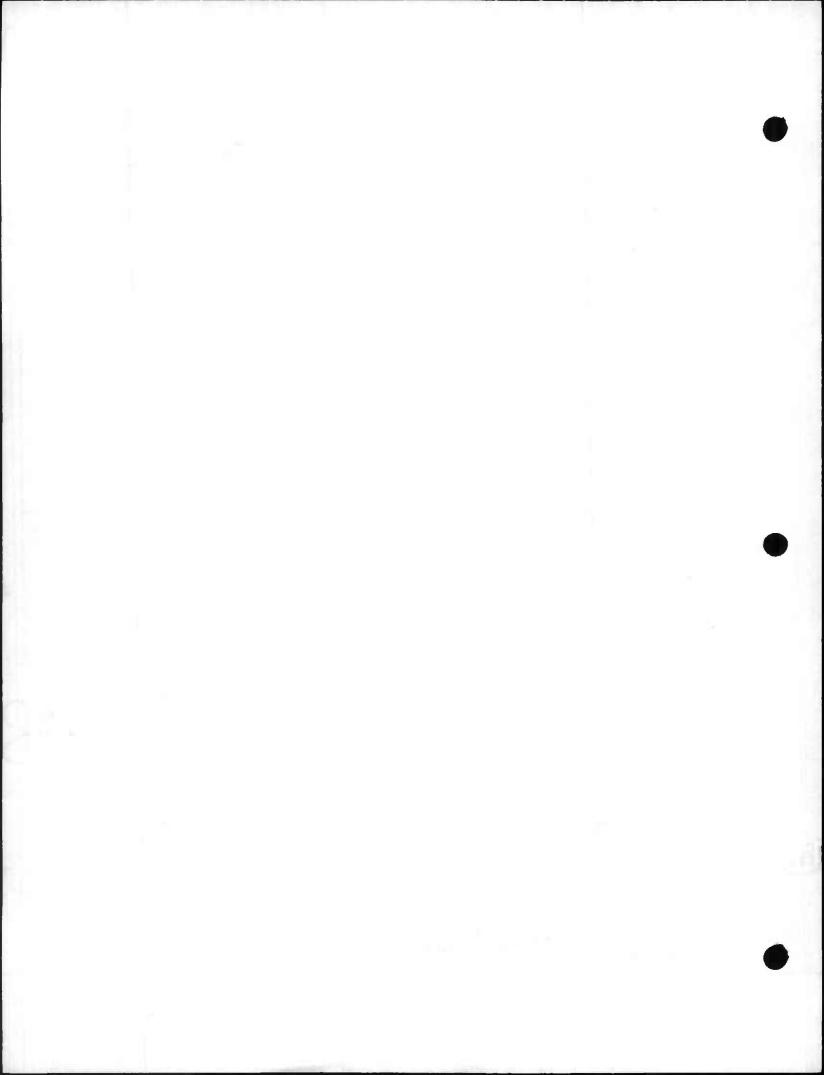
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

IF UNDER 1 YEAR

6. AGE (In yrs. last birthday)

OHMH-18 Rev 1/89



Pages 1, 2, 3 should

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use as the burial-transit

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should be detached

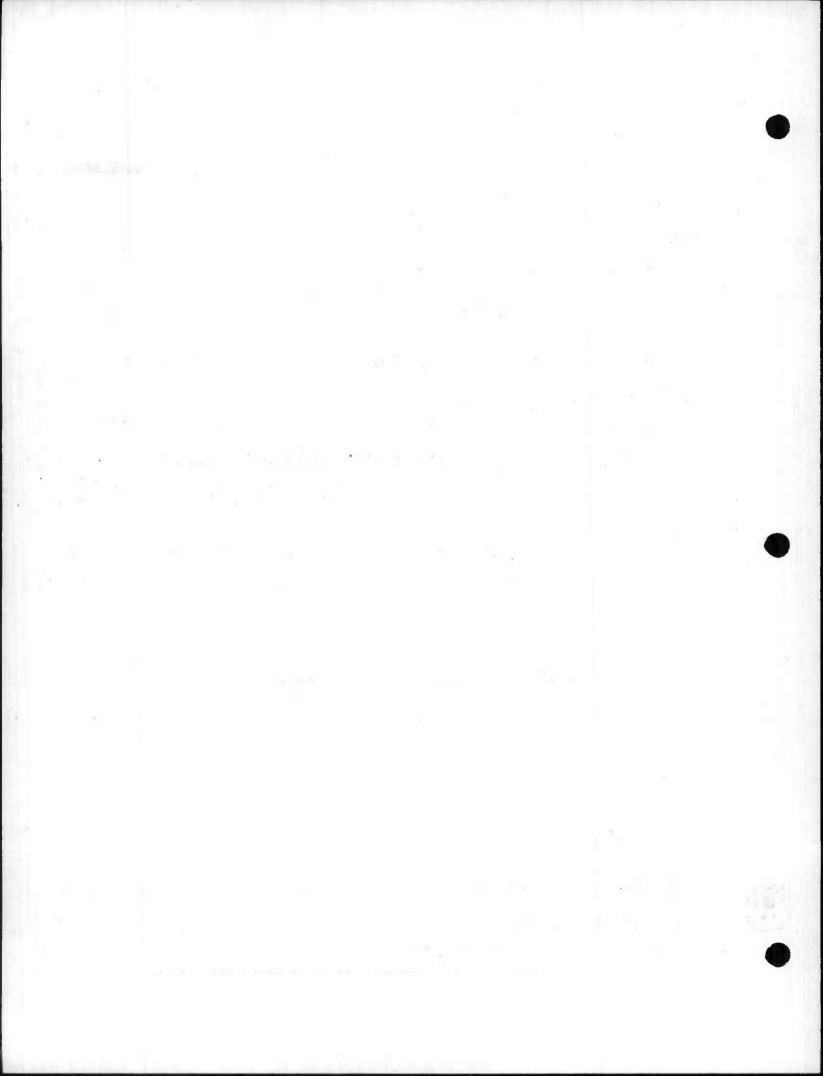
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DESTITION OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2. mouns after death. Page o may be	demonstrated by After this certificate has been signed by the attending physician and completely filled in by the funeral director, page	The within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation, or removal.	MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 4 Clifford Hinman 93 8:05P M 4. SOCIAL SECURITY NUMBER 5 SEX 5. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreign DAYS HOURS 1 🖳 M 2 🗌 F 217-03-1142 MARYLAND 12/12/10 9s. FACILITY NAME (If not institution, give street and number 96. CITY TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH DIRECTOR Pleasant Manor Nursing Center Baltimore, RESIDENCE OF DECEDENT 10d. INSIDE CITY 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Baltimore 1- YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4615 Park Heights Ave. Balto., Md. 21215 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Bleck, White, etc. If yes, specify Cuben, Mexican, Puerto Ri
1 YES 2 NO Specify: FORCES? 1 XYES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married BY 3 Widowed 4 Divorced WHITE WW 11 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple Elementary/Secondary (0-12) College (1-4 or 5+) CARPENTER CONSTRUCTION 12 0 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname, Willard Hinman Pearl Sanger 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 CASWELL AVENUE-FERNDALE, MD. 21061 JOAN BAESCH 20s. METNOD OF DISPOSITION
1 Durisi 2 Cremation 3 Removal from State
4 Donation 5 Other (Silectly) 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 20c, LOCATION - City or Town, State METRO CREMATORY, INC.4/7 CATONSVILLE, MD. 21. SIGNATURE OF FUHIRAL SERVICE LICENSEE, 22. NAME AND ADDRESS OF FACILITY 21061 RAYMOND C. FINK FUNERAL HOME 210 426 CRAIN HWY.S.W.GLEN BURNIE, MD. 0 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximeta Interval Between Onset and Death **IMMEDIATE CAUSE (Final** disease or condition resulting in death) CONGESTIVE Arteriocle The CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS ORGANIC AVAILABLE PRIOR TO COMPLETION OF CAUSE BRAIN SYN DROHE 1 TYES 2 XNO OF DEATH? FRACTYPE 1 YES 2 NO N/A PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATN (Check only one) 1 YES 2 NO 4 Nursing Nome 8 - Rasidenca 8 - Other (Specify) 1 Inpetient 2 ER/Outpetient 3 DOA 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 8 Pending investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide ED 6 Could not be 4 Homicide H 29a. CERTIFIER 1 DEERTIFYINO PHYSICIAN: To the best of my knowledge, desth occurred at the time, date and place, end due to the cause(a) and menner as stated. COMPL 2 [ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and menner as stated. 29c. LICENSE NUMBER BE D13664 d 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) C VENERAGON IN MP 1.576 merri 31. DATE FILED (Month, Day, Year) 22. REDISTRAR'S SIGNATURE 07 1993 who Davidson-Randall



MINSION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	SIAIE UF I				T OF H E OF			MENTAL HYG REG.			03021
	1. DECEDENT'S NAME (First, Middle, La MINNE	Sohnson		hns					2. DATE OF DEAT		YEAR 93	3. TIME OF DEATH  9.45 + M
	4. SOCIAL SECURITY NUMBER 085-07-3236	5. SEX	6. AGE (In yrs. les	t birthday) 2 YRS.	IF UNDER	R 1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTI (Month, Day, Ye.	4 nr)	8. BIRTH Countr	
	9a. FACILITY NAME (If not institution, gir	0	2	9b. CITY	r. TOWN O	B LOCATI	ON OF DE	3 20	11	V1r	ginia	
DIRECTOR	Ame Arundel 1	1 0	enter			napo		500,000				rundel
EC	RESIDENCE OF DECEDENT  100. STATE  100. COU	NTY	-2-311	10c. CIT	Y, TOWN	OR LOCAT	ION					10d, INSIDE CITY
DIR	Maryland Anne	Arunde:	1	0	dent	ton						LIMITS?  1)CYES 2 NO
AL	10e. STREET AND NUMBER					101.	ZIP CODI			10g. C	ITIZEN OF V	WHAT COUNTRY?
FUNERAL	630 Cadbury							113			SA	
ВУ	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Olvorced		T EVER IN U.S. AR YES 22 N			WAS DECI If yes, spe 1 TES	city Cube	F HISPANI n, Mexican Specify:	C ORIGIN? (Specif , Puerto Ricen, etc	y Yee or No—	Black	- American Indian, t, White, etc.
LED	15. DECEDENT'S E (Specify only highest gr	DUCATION ade completed)	16a. DE	CEDENT'S	USUAL O	CCUPATIO	N et of workin	· ·	16b. KIND OF	BUSINESS/II		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5	He.	Do NOT u	se retired.)		or works	v				
OMF	17. FATHER'S NAME (First, Middle, Lest)			Beau	tici	Lan	40 14077	45010 4444	ATT - 141 L			
	James Trihe	erne							ie (First, Middle, Me			
) BE	19e, INFORMANT'S NAME (Type/Print)		198	b. MAILING	ADDRESS	S (Street ar	_		oute Number, City of			21113
5	Helen Simms		6	30	Cad	bur	Dr	ive	Odent	on,	Mary	land
	20a, METHOD OF DISPOSITION  1 Surial 2 Cremetion 3 R: 4 Donetion 5 Other (Specify)	amoval from State	20b. PLACE A cemetery, cres	matory or o	ther place)	A77			4/5/93°	LOCATION -	- City or To	wn, State
	21. SIGNATURE OF FUNERAL SERVICE	LICENSIE	West	terr				S OF FAC				e, Md 1mor St.
	· Berry	Harri			L	eroy	и На	rri				,Md21217
	23. PART I. Enter the diseases, p shock, or heart faller	or complications the	t caused the da	sth. Do i	not enter	tha mod	de Df dyl	ng, such	ss cardisc or r	eapiratory a	irrest,	Approximate
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	8.	lesse	u	Ay	, ,	La	le	'n			Interval Batween Onset and Death
7		DUE TO	MA D	A A	14 ~	m	Lin					1200
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	b. DUE TO	OR AS A CONSEC	OUENCE O				(	2.00	10	11	1/2/
일	CAUSE (Disease or injury that initiated events	cDUE TO	(OR AS A CONSEC	WENCE O	F):		u	60	web	Cit		week
	resulting in death) LAST	d	Ch'	W	w	He		82	Mag			704
	PART II, Other significant conditi	ons contributing to	death but not n	esulting	In the un	derlying	Cause o	ilvan in F	Part I 24a Mile	S AN AUTOPS	v T 245	WERE AUTOPSY FINDINGS
ICAL	Hoom,	HAS	CUD,	\$	1	21	l d		PEF	REORMEO?	240.	AVAILABLE PRIOR TO COMPLETION OF CAUSE
ME	SIROH					9			_   10 46	S 2 NO		OF DEATH?
ž									_			
PHYSICIAN: MED	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER		ACE OF DI	EATH (Chec	ck only one)			
HYS	1 YES 2 NO	1 Inpatient 2 26a, DATE OF	ER/Outpatient 3	DOA 28b, TIM	Y	sing Home			Other (Specify)	ON IN HUMO	001050	
ВУ Р	1. Natural 5 Pending Investigatio	(Month, D	ay, Year)	INJ	URY M	WOF			28d. DEŞCRIBE HI	JW INJUHY O	CCUMED	
	3 Suicide 6 Could not b	28e. PLACE O	F INJURY — At hor	me, farm,	street, fact	tory, office			281. LOCATION (St. City or Town, S	reet end Numb	er or Runal R	oute Number,
	4 Homicide determined								ony or rown, o			
COMPLETED		YSICIAN: To the best of										end menner as stated.
BE	296. AGNATURE AND TITLE OF CERTIF	HER DA	LAG.	u			29c_LICE	NSE NUME	438	29d. D/	TE SIGNIO	(Month, Gay, Year)
5	30. NAME AND ADDRESS OF PERSON OF	THO COMPLETED CAUS	SE OF DEATH (ITEM	27) (Type)	Print)	RI	06	FI.	Art	#/2	) .	2/40/
	APR 07 1993	Julia David	R'S SIGNATURE	2	00		)-(	-19	,	AN	NA	ma

Russe11

4. SOCIAL SECURITY NUMBER

9a. FACILITY NAME (If not institution, give street and number)

EFFREY MULIER MI)

1993

022-20-6591

22 So GREENS St

IF UNDER 1 YEAR IF UNDER 24 H

9b. CITY, TOWN OR LOCATION (

Baltimore

HOURS

DAYS

Russell Loheed Jenkins, Jr.

64

6. AGE (In yrs. last birthday)

Jenkins

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TAL RECORDS, P.O. BOX 68760,	The faw requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician.	ate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit performance are Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
	60	Sign
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DIRECTOR 25 Elinor Avenue 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Baltimore Co. Md. Baltimore FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 25 Elinor Avenue 21 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES 13. WAS DECENDENT OF N If yes, specify Cuben, M I YES 2X NO S 1 Never Married 2 Married BY 3 Widowed 4 Divorced WWII COMPLETED 15. OECEDENT'S EDUCATION pecify only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION ast of working Elementary/Secondary (0-12) College (1-4 or 5+) 6 Years Teacher notified at once. 17. FATNER'S NAME (First, Middle, Last) IS MOTNER! Russell Loheed Jenkins, Sr. Heler BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or FI Angela 25 Elinor AVenue B Jenkins pe 20a. METNOD OF DISPOSITION
1 Seurial 2 Cremalion 3 Removal from Stala
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION /Name of must Gardens of Faith examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS O xathlun John C. Mil medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, shock, or heert fellure. List only one cause on each line. IMMEDIATE CAUSE (Finsi the disease or condition Resp Failure event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF): SMALL CEIL traumatic METASTANC CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediata csuse. Enter UNDERLYING CAUSE (Diseese or injury other OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 any Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse giver MEDICAL shows a PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL Hem HOSPITAL: h the Star 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA HOSPITAL OR ATTENDING PHYSICIAN: 4 Nursing Nome 5 Resider 27. MANNER OF DEATN 28a. OATE OF INJURY (Month, Day, Year) this c 28b. TIME OF INJURY 28c. INJURY AT WORK? Is marked, 1 Natural
2 Accident 5 Pending Investigation I YES 2 NO After BY 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 🔲 Suicide DIRECTOR: A 2 hours after of 1 Item 28 Is 8 Could not be determined COMPLETED 4 Nomicide 29a. CERTIFIER (Check only 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and FUNERAL I 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at TO THE HOSPITA
TO THE FUNERA
De filed within 7
IMPORTANT: 1 296. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE Thulle MD-Climical associate 040 2 MARLAND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

> MUCC 32. REGISTRAR'S SIGNATURE

_							
	2. DATE OF DEATH MONTH	DAY	YEAR	3. TIME OF DEATN			
	4-5-93			м			
RS.	7. DATE OF BIRTN (Month, Day, Year)		8. BIRTNPLACE (State or Foreign Country)				
	12-20-19	28		sachusetts			
OF DE	ATN	9c. COL	INTY OF D	EATN			
			Ba1	timore Co.			
_				10d. INSIDE CITY			
				LIMITS?			
		10e. CIT	IZEN OF V	WHAT COUNTRY?			
23 (	6		U.S.				
	IC ORIGIN? (Specify						
axica: pecily	n, Puarto Rican, etc.)		Black Speci	— American Indian, k, While, etc.			
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	16b. KIND OF I	BUSINESS/IN	DUSTRY				
	Baltim	ore Co	ounty	Schools			
	ME (First, Middle, Maid	len Surname)					
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	oute Number, City or 1			02.6			
alı	timore,MA	ryıan	a-21.	23.6			
		LOCATION —	City or To	wn, Stata			
	4/9	Ba1t	o. M	d			
F FAC	HLITY	6415	Bela:	ir Road			
leı	f, Inc.			Md21206			
such	ss cerdlec or res			Approximate			
		,		intarvsi Between Onset and Death			
36	- lauce						
ı in F	Part i. 24a, WAS	AN AUTOPSY	24b.	WERE AUTOPSY FINDINGS			
	PERF	ORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE			
	I U YES	2 NO		OF DEATH?			
				1 YES 2 NO			
/Che	ck only one)						
100 8	28d. DESCRIBE NOV	V INJURY OC	CUREO				
	281. LOCATION (Stree City or Town, Sta		or Rural R	loute Number,			
due t	o the cause(a) and π	nenner aa sta	led.				
the t	ime, date and place,			and menner as stated.			
NUM	I I Y	29d. DAT	F G	(Month, Dey, Year)			
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DIVISION OF VI

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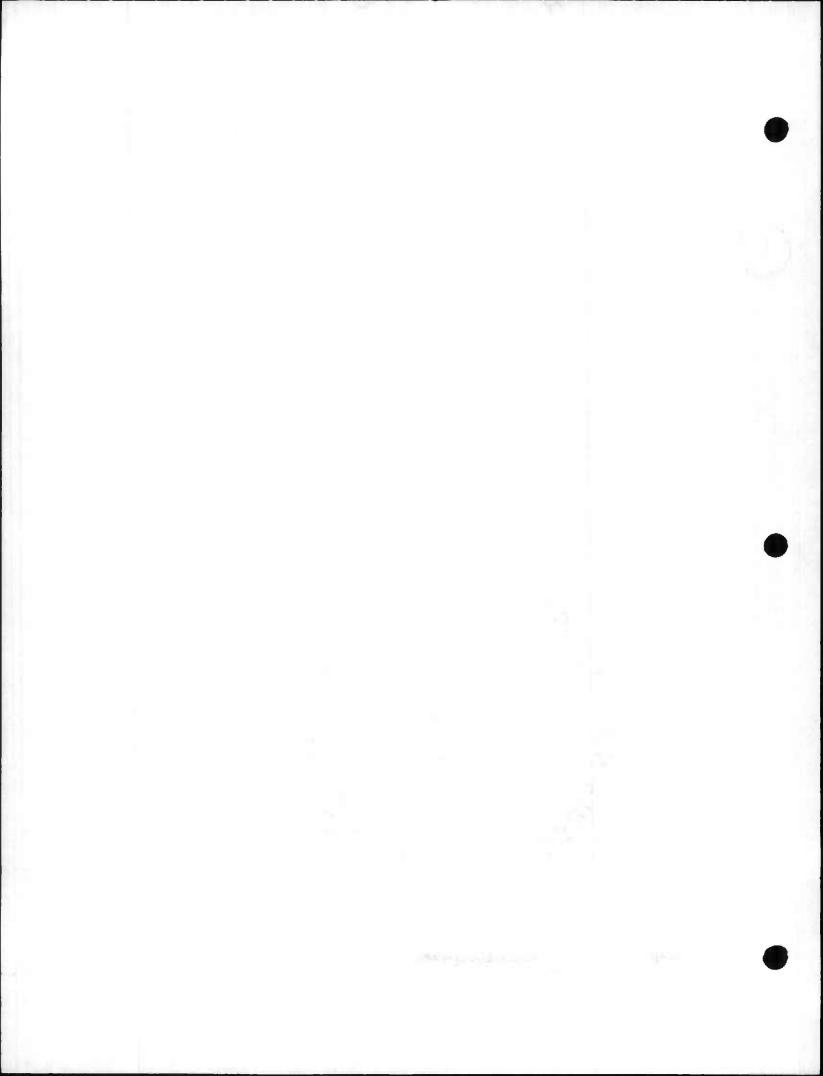
24 hours a filled in by	SIVISION OF VITAL RECORDS, P.O. BOX 68/60, BALTIMORE, MARYLAND 21215-0020
RECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-train the state beat, of Health and Mental Hydiene prior to burial, cremination, or removal	VS PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician
	for this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transference 1, 2, 3 should saft with the State Debt, of Health and Mental Hydiene prior to burial, cremation, or removal.

						93 09829
	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND		IT OF HEALTH AND	MENTAL HYGIENE REG. NO.	30 03011
- 4	1. DECEDENT'S NAME (First, Middle, Last)	1/			2. DATE OF DEATH MONTH DAY	3. TIME OF DEATH
	Thaggie	King			7-4-	93 m
	4. SOCIAL SECURITY NOMBER	5. SEX 8. AGE (in yrs. in	YRS. IF UND	ER 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign County)
	9a. FACILITY NAME (If not institution, give st	0 /	9b. C/T	TY-TOWN OR LOCATION OF D	122110	INTY OF DEATH
DIRECTOR	PRESIDENCE OF DECEDENT	ich Ave	6	Allimore	City	
IRE	10a. STATE 10b. COUNTY		10c. CITY TOWN	OR LOCATION		10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	1 1	SIT	101, ZIP CODE	100, CIT	1 PES 2 NO
FUNERAL	1428 GOR	Such Av	C	21218	2	1.5.A
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. AI FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	RMED 13	I. WAS DECENDENT OF HISPA If yes, specify Cuban, Mexic 1 YES 2 NO Speci		14. RACE — American Indian, Black, White, etc.
	15. DECEDENT'S EDUC		ECEDENT'S USUAL	OCCUPATION	16b. KIND OF BUSINESS/IN	DUSTRY DUSTRY
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)		Give kind of work done  b. Do NOT use retired.	e during most of working		
MP			Tomes	MAKEN		
BE CC	17. FATHER'S NAME (First, Middle, Last)	HAII		18. MOTHER'S NO	(First, Middle, Maiden Semame)	25
0	19a. INFORMANT'S NAME (Type/Print)	/1/11</td <td>96. MAILINO ADDRE</td> <td>SS (Street and Number or Flure)</td> <td>Number, City or Town, State, Zi</td> <td>p Code)</td>	96. MAILINO ADDRE	SS (Street and Number or Flure)	Number, City or Town, State, Zi	p Code)
	20a. METHOD OF DISPOSITION	e) Shearick 1	428 (	2015Uch	DATE 20c. LOGGTON -	Clyr oy Town, State
	1 Donation 5 Other (Specify)	ovat from State cemetery of	amatery of entrest place	DAYP) Pm	DAIL DAI	My Stand
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE /	22	NAME AND ADDRESS OF F	euss I-uner	41 Home
	Deepl	J. Kus	2 3	1325 W. No.	th Ave, BAL	timore and 21216
	23. PART I. Enter the diseases, or c shock, or heart failure. I	complications that caused the d List only one cause on each lin	eeth. Do not ente	er the mode of dying, suc	ch as cardiac or respiratory ar	Teat, Approximate interval Between
	IMMEDIATE CAUSE (Final disease or condition	T	1	0.11 0.	1	Onset and Death
	resulting in death)	DUE TO (OR AS A CONSE	EOUENCE OF):	cell ca	rainoma l	letasta 2 141
Z	Sequentially list conditions,	Transite	snal.	Cell Ca	rcinomy of	-bladden 5-44
FICATION	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONSE	EQUENCE OF):		¥ *	
IFIC	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CONSE	EQUENCE OF):			
CERI	resulting in death) LAST					
	PART II. Other significant conditions	s contributing to deeth but not	resulting in the u	underlying ceuse given in	Part I. 24s. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
MEDICAL					1 - YES 2 0 NO	COMPLETION OF CAUSE OF DEATH?
					_   / ·	1 TES 2 NO
SICIAN:	25. WAS CASE REFERRED TO MEDICAL			26. PLACE OF DEATH (C	heck only one)	
Sic	EXAMINER?  1 YES 21 NO	HOSPITAL: 1   Inpatient 2   ER/Outpatient :	3 DOA 4 N	R: ursing Home 5 - Residence	6 Other (Specify)	
РНУ	27. MANNER OF DEATH  1 Netural 5 Pending	26e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DEŞCRIBE HOW INJURY OC	CURED
BY BY	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY — At h	ome, farm, street, fa		281. LOCATION (Street and Number	r or Rural Route Number,
TED	4 Homicide determined	building, atc. (Specify)			City or Town, State)	
COMPLET		CIAN: To the best of my knowledge, d				
Ö	2 MEDICAL EXAMINER	R: On the basis of examination and/or	Investigation, to my			
BE	296. SIGNATURE AND TITLE OF CERTIFIER	her Ho		29c. LICENSE NU	MBER 29d. DAT	TE SIGNED (Month, Day, Year)
2	30, NAME AND ADDRESS OF PERSON WHO		EM 27) (Time Brint)			11617

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29d. DATE SIGNED (Month, Day, Year)

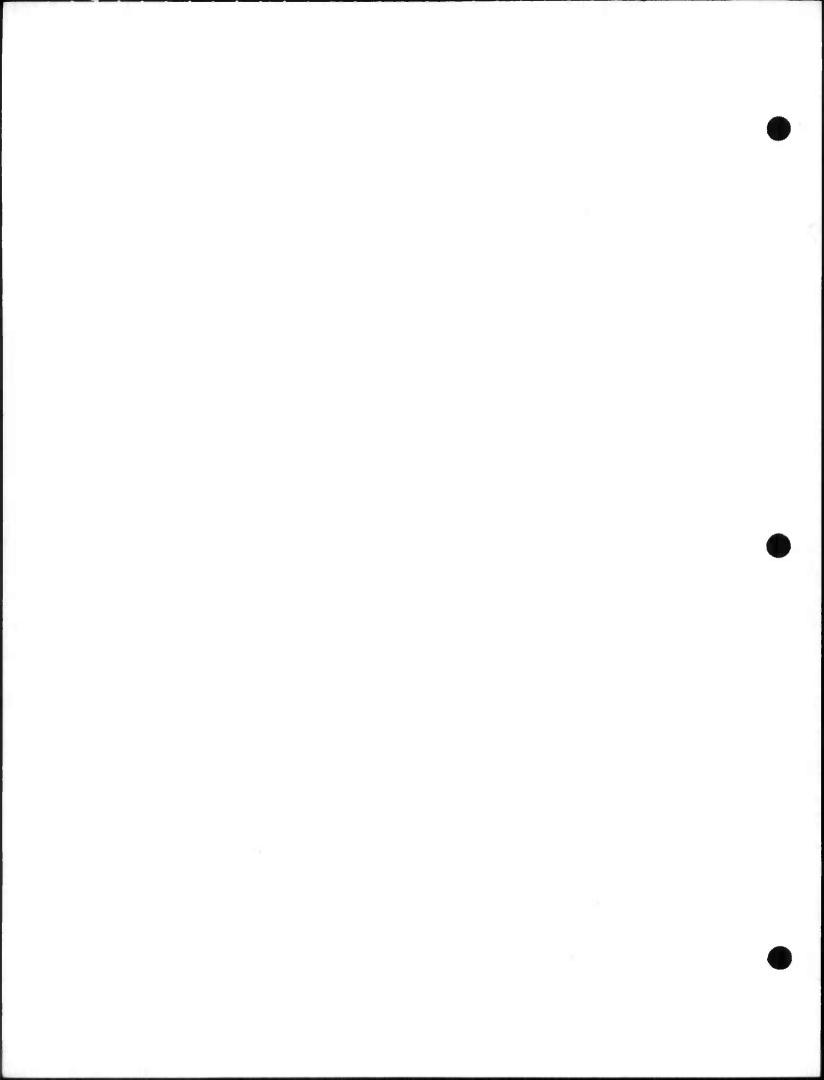
4/6/93 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 30. NAME AND ADDRESS, OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 31. DATE FILED (Month, par, Years

APR - 7 1993



	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach		IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	M Pi	omple	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ever
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	1 - FOR STATE REGISTRAR	STATE OF I	MARYLAND /		RTMENT O					IENE . NO.	20	03030
	1. DECEDENT'S NAME (First, Middle, Last)			_					2. DATE OF DEA	TH		3. TIME OF DEATH
	MICHAEL	Eline	ne,	I	YLES				04 0!	5 MY 199	3	2:45 A M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las		IF UNDER 1 Y	EAR	IF UNDER 24	HRS.	7. DATE OF BIRT	н		PLACE (State or Foreign
	216-62-1445	1 1 1 1 1 2 □ F	39	YRS.	MONTHS D	AYS I	HOURS	MIN.	(Month, Day, Ye	50	Country	ruland
	9a. FACILITY NAME (If not institution, give :	street and number)			9b. CITY, TO	OWN OR	LOCATION	OF DEAT	TH	9c. COUR	TY OF DE	ATA
CTOR	614 EAST 29TH	STREET			101		MORE					~
DIREC	10a. STATE 10b. COUNT	Υ		10c. CIT	Y, TOWN OR L	LOCATIO	N					10d. INSIDE CITY
=	maryan			1	3A/1	im	ord				- 1	LIMITS?
4	10e. STREET AND NUMBER	+1.	1		,,,,,,	1	IP COOE			10g. CITI		HAT COUNTRY?
1	1014 FAST	29'1.	5/00	P		5	12	18		/	1. 5	T. A.
FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN	IT EVER IN U.S. AR	MED	13. WAS	DECEN	DENT OF	HISPANIC	ORIGIN? (Speci	ty Yea or No.—	14 RACE	- American Indian,
	1 A Never Married 2 Married	FORCES? 1	YES 2 124	NO	If ye	s, speci	fy Cuban, I	Mexican,	Puerto Rican, et	c.)	Black,	White, atc.
BY	3 Widowed 4 Divorced				1 '	,	(Date	opechy.			B/	ACK
8	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)			USUAL OCCU		of working		16b, KIND O	F BUSINESS/IND	USTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5	life	Do NOT us	se retired.)	1	- Working					
COMPLET			1	1,5,	9.b]/j	14						
8	17. FATHER'S NAME (First, Middle, Last)	601	/	/		01	MOTHER	R'S NAME	E (First, Middle, M	alden Sumame)		4
HE HE	Norman 11	MAIN	1 /4/6	25		<u> </u>	MA	RC	elene	0	We	eT
2	19a. INFORMANT'S NAME (Type/Print)	) n	19	b. MAILING	ADDRESS (St	treet and	Number or	Aural Rou	ute Number, City o	or Town, State, Zip	Code)	/ .
-	1115, CArolyn	DeBeri	ry 0	25/	2 QU	100	V Ar	me	Kd. K	SAID.	ma	.21216
	20a. METHOD OF DISPOSITION  1 Burial 2 Cremetion 3 Rem	oval from State	20b. PLACE	AND DATE	OF OISPOSITIO	N (Name			T	c. LOCATION -	Cify or Tow	n, Steta
	4 Donation 6 Other (Specify)	- Tom Otale	complery, cre	Per 1	her biace	m.				OALT	nor	e md.
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE			22. MAR	WE AND	ADDRESS	OF FACE	OTY F	UNERI	4/	Home
	Joseph	L. Ru	15		00	541	(/) ~	-/ /	000			
	23. PART. Enter the diseases, pr shock, pr heert feilure.	List Dniy Dne ceu	ise on each line	eth. Do r	not enter the	mode	of dying	, such :	as cerdiac or	respiratory arm	est,	Approximate interval Between
	IMMEDIATE CAUSE (Finei disease or condition					- 1						Onset and Deeth
	resulting in deeth)	e. Arter	(OR AS A CONSE			rdl	ovas	cul	ar Di	sease		
2					7-							
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A CONSEC	DUENCE OI	F):							
8	cause. Enter UNDERLYING	e.										
Ē	CAUSE (Disease or injury that initiated events	DUE TO	(OR AS A CONSEC	QUENCE OF	F):							
E	resulting in death) LAST	d										
Ö	DART II Other electrices and discon-											
₹	PART II. Other eignificent condition	e contributing to	deeth but not r	esulting	in the under	rlying c	euse give	en in Pe	ort i. 24a. WA	S AN AUTOPSY RFORMED?		WERE AUTOPSY FINDINGS
ă									_ 1 _ YI	ES 2XX10		COMPLETION OF CAUSE OF DEATH?
M									_			I □ YES 2 □ NO
PHYSICIAN: MEDICA												
8	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:				6. PLAC	E OF DEAT	TH (Check	conty one)			
\Z	1 TYPES 2 - NO	1 Inpatient 2	ER/Outpatient 3	□ DOA	OTHER:	Home	5 Resid	lence 8	Other (Specify	)		
표	27. MANNER OF DEATH	28e. DATE OF (Month, D		28b. TIM	E OF 28c	. INJUR	Y AT	2	ad. DEŞCRIBE H	OW INJURY OCC	URED	
B	1 Natural 5 Pending 2 Accident Investigation						2 🗌 N	10				
E	3 Suicide 6 Could not be	28a. PLACE O building,	F INJURY A1 ho	me, farm, s	street, factory,	office		2	Bf. LOCATION (S. City or Town,	treet and Number (	or Rural Ro	ute Number,
	4 Homicide determined								on, or 10,771,	313107		
COMPLET	29a. CERTIFIER (Check only 1 CERTIFYING PHYSI	CIAN: To the best of	my knowledge, de	ath occurre	d at the time,	data an	d place, en	nd due to	the cause(a) and	f manner as state	d.	
NO	000) 2 MEDICAL EXAMINE											and manner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIE						Dc. LICENS					Month, Day, Year)
8	D 1 00	2				1		.M.				5/1993
임	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUS	SE OF DEATH (ITE	W 27) (Type	Print)		0.0		<b>.</b>	1,0	1,00	,, 1,,,,
						I	D -	1 + -	mo×-	M 7	and	21201
	31. DATE FILED (Month, Day, Mar) APR - 7 1993	32. FEGISTRA	P'S SIGNATURE	renn	SUL	eet	, Ba	1111	шоте,	Maryl	and	21201
	APR - / 1993	gular	SIGNATURE	ind all	•							



BALTIMORE, MARYLAND 21215-0020

TO BE COMP	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
examiner must be notified at once.	IMPORTANT: It Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
al.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
e funeral director, page 5 should be detached	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached
r death. Page 6 may be retained by the hosp	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospi

	Ambrose A	Albert	Leimku	hler				MONTH 4	-6-93	YI.	EAR	6:00 A. M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yr	rs. lest birthday)	IF UNDER		ER 24 HRS.	7. DATE O	F BIRTH Day, Year)	8.	BIRTHPL	LACE (State or Foreign
	212-01-5255	1 🔀 M 2 🗆 F	80	YRS.	MONTHS	DAYS HOURS	MIN.		-1912	E	Salt	imore, Md.
3	9a. FACILITY NAME (If not institution, give	ACILITY NAME (If not institution, give street end number)				TOWN OR LOCA	TION OF DE	EATH		9c. COUNTY		
O.	16 Skywood Court		Par	rkville				Bal	Ltim	ore County		
2	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNTY											
DIRECTOR	Md. N/A					altimor	. Cit	v				Od. INSIDE CITY LIMITS? X YES 2 NO
	10e. STREET AND NUMBER					10f. ZIP CO		-1		10g CITIZEN		AT COUNTRY?
FUNERAL	3440 Mount H	Pleasant	Avenue			212	24			7.5	J.S.,	
S	11. MARITAL STATUS	12. WAS DECEDEN	NT EVER IN U.S	SARMED	13. W	AS DECENDENT		IC ORIGIN?	(Specify Yee o			- American Indian,
	1 Never Merried 2 Merried	FORCES? 1	MAR OR DATES	₩ NO	11	yes, specify Cui	oan, Mexice	n, Puerto Ric	cen, etc.)		Black, \ Specify:	White, etc.
ВУ	3 Widowed 4 Divorced										ореску.	White
Ä	15. DECEDENT'S EDI (Specify only highest grad	UCATION le completed)	164	. DECEDENT'S	work done di	CUPATION uring most of work	kina	16b. F	UND OF BUSH	NESS/INDUST	TRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5	+)	life. Do NOT us	se retired.)							
N N	6th Grade			Bethl	ehem	Steel			Stee1	Worke	r	
	17. FATHER'S NAME (First, Middle, Last)					18. MO	THER'S NA	ME (First, Mic	ddle, Maiden Su	ımame)		
BE	John Leimk	uhler					Amand	a G	ellert	-		
2	19e. INFORMANT'S NAME (Type/Print)		4			(Street and Numb						
'	Thelma E. Lein	nkuhler	71 -				ant A	venue	Balt	imore	, MD	. 21224
	20e. METHOD OF DISPOSITION  1  Burlel 2 Cremetion 3 Ren	moval from State	cemetery	ACE AND DATE	ther place)	11.55		DATE	20c. LOCA	TION — City	or Town	, Stata
	4 Donetion 5 Other (Specify)		- Pa	rkwood	CEme			4-9	Ba1	timor	e,M	D
	21. SIGNATORE OF FUNCHAL SERVICE L	CENSEE	1			AME AND ADDR						r Road
	Jathleen	M. Mur	when									Md21206
	23. PART i. Enter the diseases, or shock, or heart failure.	complications the	it caused the	e death. Do r	not enter t	the mode of d	ying, suct	n ss cerdis	c or respira	tory srrest,	,	Approximats Interval Between
	IMMEDIATE CAUSE (Finel		-									Onset and Death
	disesse or condition resulting in death)	. (-	nos	NSEQUENCES	eine	ca	reia	ma				,
n												/ CAA>
		DUE TO	(OR AS A CO	NSEQUENCES	F):							140
NO	Sequentially list conditions,	b										190
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	b		NSEQUENCE OF								190
IFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	b. OUE TO	(OR AS A COR		F):							/90
RTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	b. OUE TO	(OR AS A COR	NSEQUENCE OF	F):							/4/
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted events resulting in death) LAST	b. OUE TO  C. DUE TO  d.	(OR AS A COP	NSEOUENCE OI	F): F):							/4/
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: MEDICAL	If siny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted events resulting in desth) LAST  PART II. Other significant conditions  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 NO	b. OUE TO  C. DUE TO  d.	(OR AS A COP	NSEQUENCE OF	OTHER:	lerlying cause	given in I	Pert I. 2	4s. WAS AN AU PERFORMI YES 2	ED?	AV CC OF	AILABLE PRIOR TO DMPLETION OF CAUSE F DEATH?
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	Pages 1, 2, 3 should	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hoseital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dect. of Health and Mental Hydrene prior to burial, cremation, or removal.	IPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSP	TO THE FUNE be filed within	IMPORTANT

Mez

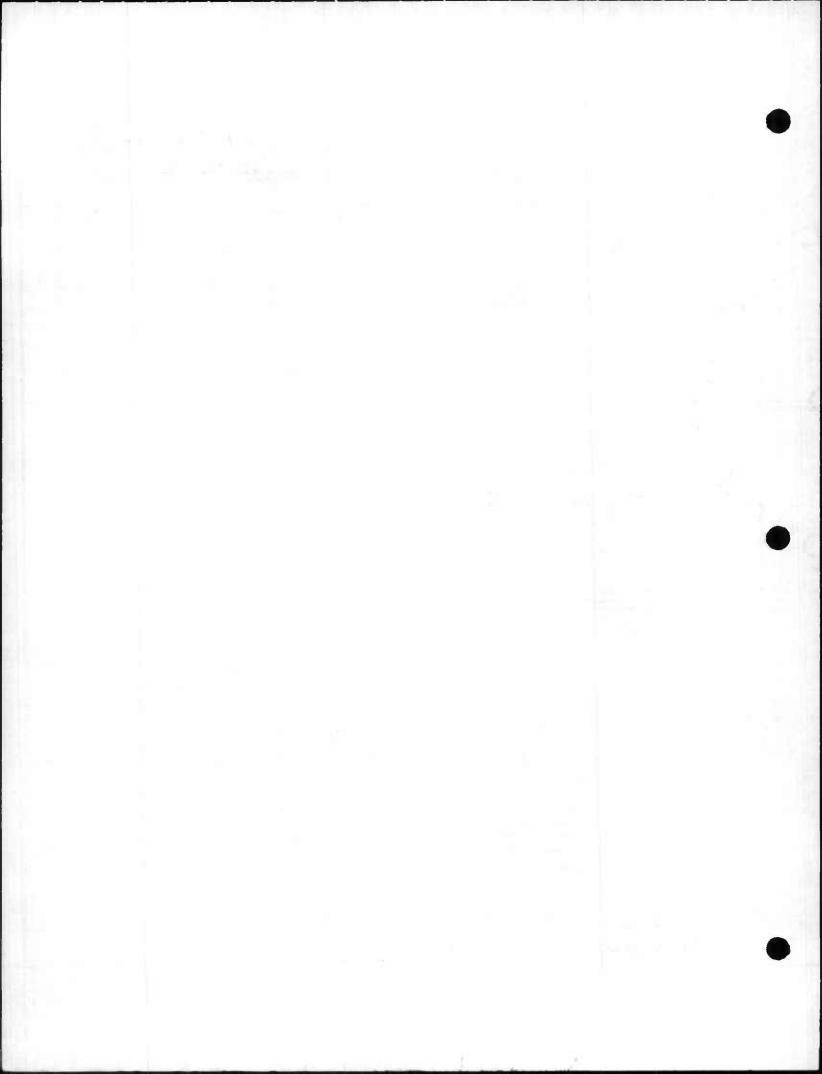
APR 6 1993

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32. REGISTRAR'S SIGNATURE

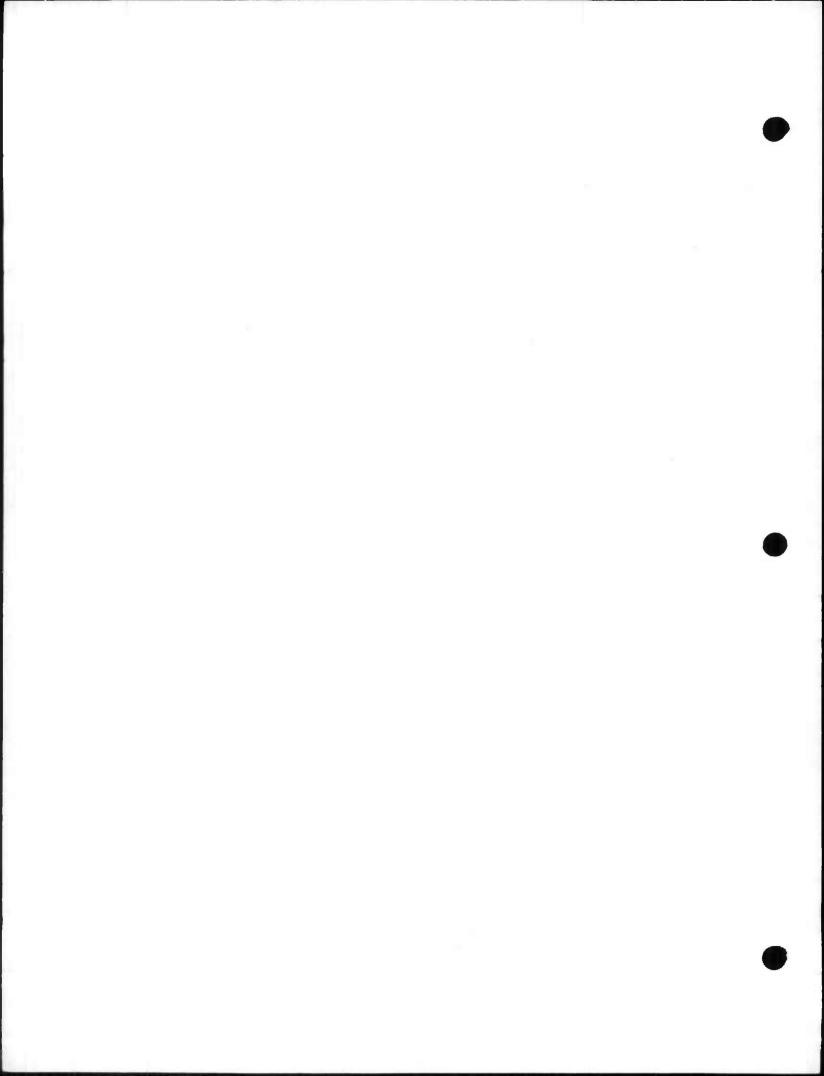
1. DECEDENT'S NAME (First, Mic		0.5		CERTIF					2. DATE	REG. NO	DAY	YEAR_	3. TIME	OF DEATH
Georgette					,				0	10	2	93	10	2:05
		SEX	6. AGE (In yrs.	last birthday) YRS.	IF UNDE	DAYS	IF UNDER	24 HRS. MIN.	7. DATE	OF BIRTH		8. BIRTH Country	PLACE (	State or Foreign
022-38-339			98	THS.	01.077					-25	-95	FRA		3
Citizen and Citizen and Citizen			3				R LOCATION		EATH			NTY OF D		
FAIRHAVEN	DENT	Third	Ave.		Syl	cesv	i111	e,			JCAR)	ROLI	,	
	b. COUNTY					OR LOCAT							10d. INS	HDE CITY
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	J 7					100	ZIP CODI				100	ZEN OF W	HAT CO	JNTRY?
7200 Thire		2. WAS DECEDEN	T EVER IN U.S.	ARMED	13		1784		NIC OBIGI	N? (Specify Ye	US		Amer	ican Indian,
1 Never Married 2 Mail 3 Wildowed 4 Divorced	rried	FORCES? 1 IF YES, GIVE W	YES 2			If yes, spi	2 NO	n, Maxica	in, Puerto	Rican, etc.)		Black	, White,	ite
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Elementary/Secondary (0-12) H . S .		College (1-4 or 5 +	)	each						m	ah :			
17. FATHER'S NAME (First, Middle				eacil	ing	rre					cher			
Charles Can										Middle, Maide	,			
19a, INFORMANT'S NAME (Type/				19b. MAILING	ADDRES	S (Street a				ber, City of To		Codel		
Jacqueline	2 I. I	Wilson		92	25 D	ark	λπο	N	OM.	Vork	028	NT.	3.7	
20a. METHOD OF DISPOSITION				E AND DATE	OF DISPO	SITION (Na	me of	. IV	DAT	York	DCATION —	City or To	wn, State	
1 Donation 6 Other (Spi		t from State	Cari	crematory or o	other blace.	}								
21. SIGNATURE OF FUNERAL SE					616	тат:	l On		4/	3 Ham	neta	20	Ma	
. 7	ERVICE LICENS	SE	1001	.011	22.	NAME AN	D ADDRES	SS OF FA	QUITY	3 Ham	pste	ad,	Md	
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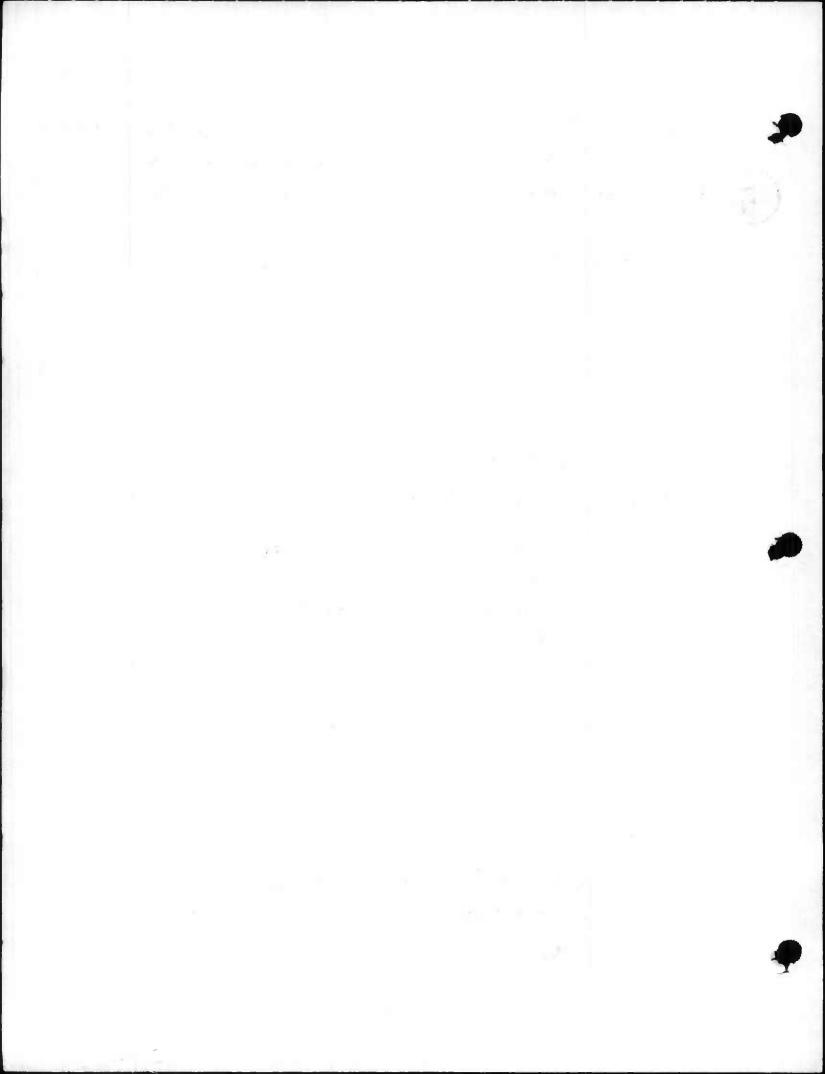
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			1. DECEDENT'S NAME (First, Middle, Last)								OF DEATH			3. TIME OF DEATH
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			4. SOCIAL SECURITY NUMBER	S. SEX 6. AGE (In	yrs. lest birthday)	IF UNDER		IF UNDER			OF BIRTH		6. BIRTH	PLACE (State or Foreign
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AN	the hospital detached fo once.	COMPLETED	17. FATHER'S NAME (First, Middle, Lest)			_		18. MOT	HER'S NAI	ME (First, I	Aiddle, Maiden	Sumame)		
RYLAND	# & &	В	Phillip Messersm	th				Marg	aret	Mar	ynard			
AB	5 should be	m	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS			_		per, City or Tow	n, State, Zip	Code)	
_		2	Elliot Lewis, Att	7	1 E.	Lexi	nato	on S	t.Ba	lto	MD 212	0.2		
ALTIMORE,	ter death. Page 6 may be in the funeral director, page 5 wal.	1	20a. METHOD OF DISPOSITION	20h I	LACE AND DATE				0,200.	DAT		CATION —	City or To	wn, State
ō	0 0 -		1 Buriel 2 Cremation 3 Remove 4 M Donation a Other (Specify)	of from State ceme	tery, crematory or c	ther place)								1012201
=	death. Page tuneral direct.		21. SIGNATURE OF PUNERAL SERVICE LICEN	See Donn 1 3 13		22.	NAME AN	D ADDRE	SS OF FAC	YTUK				
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8	rs after removal	7	23. ART I. Enter the diseases, or con	nolications that caused	the death Do	not enter	the mo	Balt	Ing and	est,	Balto	.MD21	201	I Assessed
	3		snock, of heart failure. Li	t only one cause on each	ch line.	not onter	are mo	ue or uy	ing, suci	I as care	nac or resp	iratory arr	est,	Approximate Interval Between
	file tion.	1	IMMEDIATE CAUSE (Final disease or condition	Acuto	Rossi	- 1		En	. 0					Onset and Death
0	ted within 24 completely fille ial. cremation.		resulting in death)	DUE TO (OR AS A	CONSEQUENCE	e.	0	-	~~~	CII.				8
68760,	8 5 - 6	- 1		COPP	>	- /-								
9 X	ertificate be executed ing physician and com glene prior to burial, other traumatic ev	RTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (DR AS A	CONSEQUENCE D	F):								
	ysiciar prior trau	8	cause. Enter UNDERLYING											
0.	nding ph Hyglene or other	E	that initiated events	DUE TO (OR AS A	CONSEQUENCE O	F):								
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4	12 G as a	A N	25. WAS CASE REFERRED TO MEDICAL				26 84	ACE OF D	EATH (Ch.		-1			
_	f e e 5	SICIAN	EXAMINER?	IOSPITAL:		OTHER	t:		EATH (Che		•			
7	the the	PHYS	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIN		ing Home		sidence		(Specify)	N REEV OC	HIDED	
OF	Te kits		1. Natural 5 Pending	(Month, Day, Year)	IN.	JURY	WO	RK?	NO.	zeu. Deg	CHIDE HOW I	NJUHT OCC	ONED	
O	NDING T. After r death	à	2 Accident Investigation 3 Suicide B Could not be	26a. PLACE OF INJURY -	- At home, farm,	street, facto			] 110	28f LOC	ATION (Street	and Number	or Rumi F	Inute Number
S	after 28		4 Homicide B Could not be detarmined	building, atc. (Specif	7)		,				or Town, State)		or riorer r	out Hamber,
DIVISION	DR ATTENDING DIRECTOR: After hours after death item 28 is ma	Ē	29e. CERTIFIER	N. To the best of an incident	an war	1711-0 G	- 100	7/401	10000					
۳,		COMPL		N: To the best of my knowle On the basic of examination										
	TO THE HOSPITAL TO THE FUNERAL DE filed within 72 P	8		on the same of examination	entaron (investigatio	on, m my o	pirion, de				and place, an			
	<b>2 1 1 1 1 1 1 1 1 1 1</b>	8	296. SIGNATURE AND TITLE OF CERTIFIER		1 n	0.10		29c. LICI	ENSE NUM	BER		29d, DATE		(Month, Day, Year)
	2 2 3 X	<u>0</u>	TO NAME AND ADDRESS OF DEPOSON WHILE	Kundel	1	YVV )		C	1 28	VV			112	193
			30. NAME AND ADDRESS OF PERSON WHO											
			DR RANDALL 1205	York Road	#33, Lu	ither	vill	.e, M	ID 2	1093				
			31. DATE FILEA PR 007 1993	32. REGISTRANG SIGNAT	W Production	4								
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DALL MANILAND SISONS SING	¿frours after death. Fage 6 may be retained by the hospital or attanding physician.  I filled in by the funeral director, page 5 should be detaiched for use as the burish-travalt permit.	maton, or remova. f, the medical examiner must be notified at ence.	
DIVISION OF VITAL RECORDS, F.C. BOX 13129,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed will chosen after death. Page 6 may be retained by the law requires that the death of the attending physician and comp. If filled in by the funeral director, page 5 should be deached to use as the burish fravell permit.	be filed within 72 hours after death with the State Dept. of Heath and Mental Hyperle prior to burial, crematorl, or removal.  IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at ence.	

FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND M CERTIFICATE OF DEATH		YGIENI EG. NO.	_
CEDENT'S NAME (First, Middle, Last)		2. DATE OF I	DEATH DA	, Y

Baby Boy M	MILLER						2. DATE OF I	2.8	YOU TEAR	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER 1	$\overline{}$	IF UNDER 24 HRS.	7. DATE OF E (Month, De	HRTH V. Ybar)	-	THPLACE (State or Foreign ntry)
98. FACILITY NAME (If not institution, give FRANCIS SCOTT		DON C	STR			LOCATION OF E	EATH	111-	c. COUNTY OF	dans.
RESIDENCE OF DECEDENT  10a, STATE  10b, COUR	VTY		10c. CIT	Y, TOWN OF	R LOCATIO	ON				10d. INSIDE CITY
Maryland			Can	pital	Неі	ghts				1 YES 2 NO
100. STREET AND NUMBER 1107 Capital	View Dri	ve			10f.	ZIP CODE 20	743	1	10g. CITIZEN OF USA	WHAT COUNTRY?
11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES?	NT EVER IN U.S. AR 1 YES 2 II WAR OR DATES	MED NO	If	yes, spec	NDENT OF HISP/ city Cuben, Mexic 2 NO Spec	an, Puerto Ricar		Bia	CE — American Indian, ick, White, etc.
15. DECEDENT'S EI (Specify only highest gra Elementary/Secondary (0-12)		(G		USUAL OC work done do se retired.)			16b. KIN	ID OF BUSIN	ESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last)						16. MOTHER'S N	AME (First, Midd	le, Maiden Sui	mame)	
19a. INFORMANT'S NAME (Type/Print)		12	6 MAR 18-	ADDRESS	(Diss )	Joyce		Diby on Town	State The Cod :	
Jovce Miller		4770 C C C C C C C C C C C C C C C C C C	D. MAILING	ADDHESS	(Street an	d Number or Rura	rioute Number, (	HIY OF TOWN, S	эк <b>атв, 410 U008)</b>	
20a. METHOD OF DISPOSITION  1 Buriel 2 Cremetion 3 Red 4 Donation Char (Specify)	moval from State	other pi	OF DISPO	SITION (Nan	ne of cem	etery, crematory or		20c. LOCA	TION — City or	Town, State
21. SHOHATURE OF FUHERAL SERVICE	ucenser Rona	ld Wade,	Dir 5/93			altimor	S			y Board
Sequentially list conditions, if eny, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	B RDS  DUE T  DUE T	O (OR AS A CONSE MOURA TO (OR AS A CONSE	QUENCE O	HEN	HOF	RHAG	Œ			
resulting in death) LAST	" PRE	MATI	XKI	7						
PART II. Other eignificent condit	ions contributing (	to deeth but not	reaulting	in the un	derlying	ceuse given i		e. WAS AN AL PERFORMI	ED?	4b. WERE AUTOPSY FINDIN AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?  1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL					26. PL	ACE OF DEATH (	Check only one)			
EXAMINER?  1 TYES 2 NO	HOSPITAL:	□ ER/Outpatient	3 🗆 DOA	OTHER		6 Residenc	6 Other (S	pecify)		
27. MANNER OF DEATH  1 Natural 6 Pending Investigation Investigation		Dey, Year)	28b. TIR	NE OF JURY M	28c, INJU WOI 1 Y		28d. DESCR	BE HOW INJ	URY OCCURED	
2 Accident Investigation 3 Suicide 6 Could not determined	be 28e. PLACE building	OF INJURY — At hig, etc. (Specify)	ome, farm,	street, fecto	ory, affice			ON (Street and jown, State)	d Number or Run	al Route Number,
one)	IYSICIAN: To the best									e(s) and menner as stated
295, SIGNATURE AND THE OF CENTI	FFY 1 OL A	M -	_			29c. LICENSE N	UMBER	. 2		ED (Month, Day, Year)
30. NAME AND ADDRESS OF PERSON	great		٠ .			DH.	2046	2	3 3	18143



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit,	rithin 7.	18 Marie 20 to marked on lane 30 shows and latinary bearinged about the modern and an extension of the market of the sample of t
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31. DATE FILED (Month, Day, Year) 07 1993

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Alma YEAR Martinez 04 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 213-18-2237 1 🗌 M 2 🔲 F MD 2-1-19 ages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and n 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH FUNERAL DIRECTOR Liberty Medical Center Balto RESIDENCE OF DECEDENT Maryland 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore 1 X YES 2 . NO 10s. STREET AND NUMBER 10f. ZIP CODE log. CITIZEN OF WHAT COUNTRY? 2324 McCulloh St. 21217 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 13. WAS DECEMDENT OF HISPANIC ORIGIN? (Specify Yes or No If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 □ YES 2 □ NO Specify: FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married ВҰ 4 Divorced **Black** COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Board of Education 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Webb Lemmons Ida Dyson BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Yvonne Holland Morgan 2324 McCulloh St. Balto. Md. 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE Garrison Forest Vet. Cem 4-8 Owings Mill, Md. 21. SIGNATURE OF FUHERAL SERVICE LIGENSEE 22. NAME AND ADDRESS OF FACILITY William C. Brown Community Funeral Home 1206 W. North Ave. Balto. Md 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Approximate interval Betw IMMEDIATE CAUSE (Final Onset and Death disease or condition Cuncer -ung resulting in death) DUE TO-OR AS A CONSEQUENCE OF .: PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause, Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 HO OF DEATH? 1 | YES 2 | NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

1 24 YES 2 NO 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: se 5, Residence 6 🗆 Other (Specify) 4 D Nurs 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 5 Pending Investigation 1 Natural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — Al home, farm, street, factory, office building. etc. (Specify) 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 29e. CERTIFIER
//Check only

CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner as stated. 2 MEDICAL EXAMINER: On the basis occured at the time, date and place, and due to the cause(e) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, 29c LICENSE NUMBER BE TO THE TO THE De filed V Eune 2 04 9 MAG 03 2 30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) medical

Z.berry 2600

Sula Laura Anna Signature

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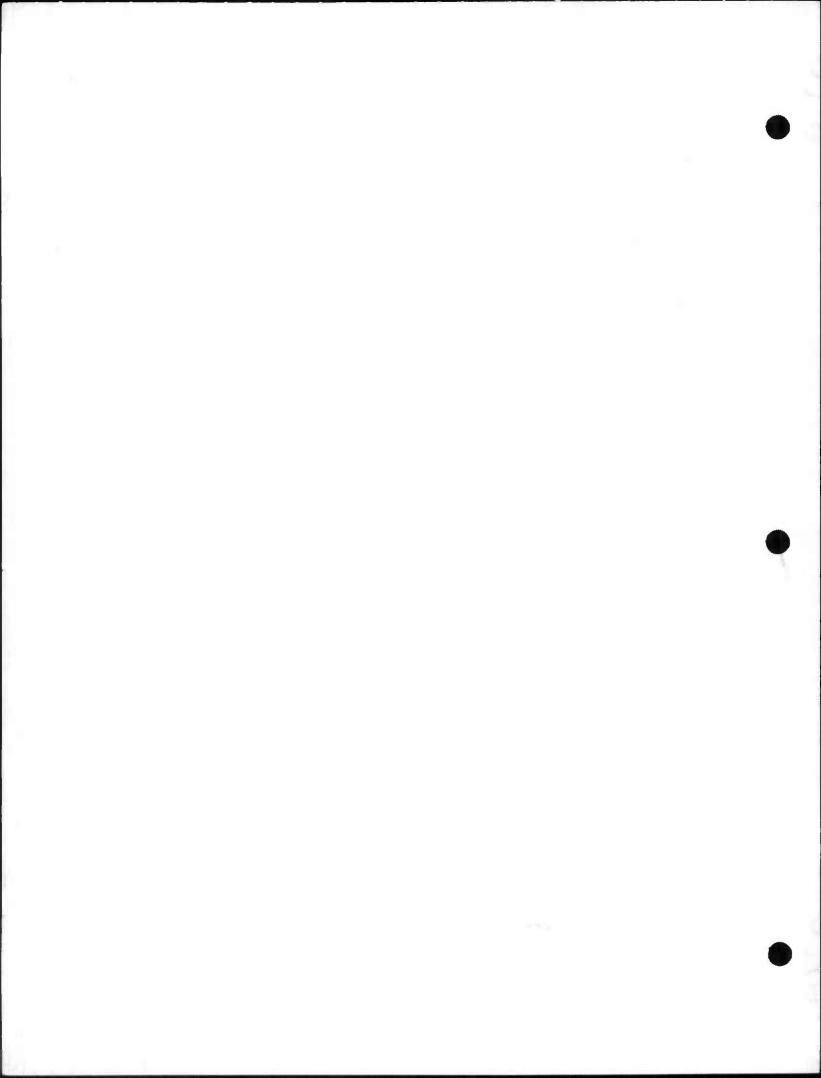
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be medically minim. Froms after death. Page 6 may be retained by the hospital or attending physic	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriativa	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal,	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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93 09836 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH Marsh udHh 6. AGE (In yrs. last birthday)
YRS. 4 SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 235-1 - M 2 W F TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH FUNERAL DIRECTOR MOR 10c. CLAY, TOWN OR LOCATION 10d. INSIDE CITY 1 YES 2 NO 101. ZIP CODE 6 12. WAŚ DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yea, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indien, Black, White, etc. FORCES? 1 YES 2 1 Never Married 2 Marrie ВУ 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most the Do NOT use retired.) (Specify only highest grade compl Elementary/Secondary (0-12) College (1-4 or 5+) ST. FATHER'S NAME (First, Middle, Long) BE 2 ETHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION DATE on 5 D. Ottoer (Specify) and 23. PART | Enter ine diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiec or reapiratory abook, or haert feliure. List only one cause on each line. Approximata interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition MULTISYSTEM Organ failure
DUE TO (OR AS A CONSEQUENCE OF): resulting in death) sepsis CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): immuno compromised OUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST myelocytic PART ii. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE renal failure 1 THES 2 NO disseminated OF DEATH? intravascula coaquiation 1 - YES 2 70 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 | YES 2 | NO ne 5 🗆 Residence 8 🗆 Other (Specify) 4 🗌 Nun 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 5 Pending Investigation 1 Netural ВҰ 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Sulcide 8 Could not be determined 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) BE COMPLETED 4 Homicide 2 MEDICAL EXAMINER: On the be 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year, 4/5 193 2 IN NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DISTANCE PRINTING PRINTING AND THE TOTAL TO SPITAL Gulle DESTINANT HOMELE APR 07



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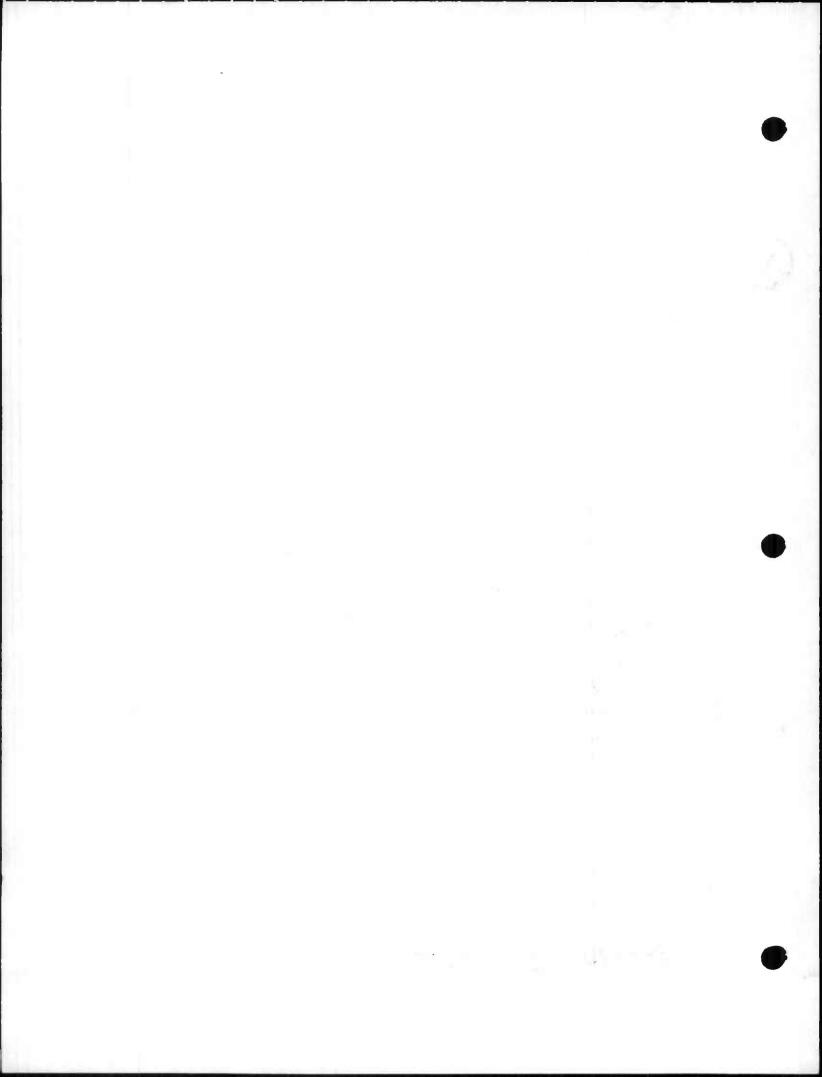
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31. DATE FILED (MONTH, Day, Year)

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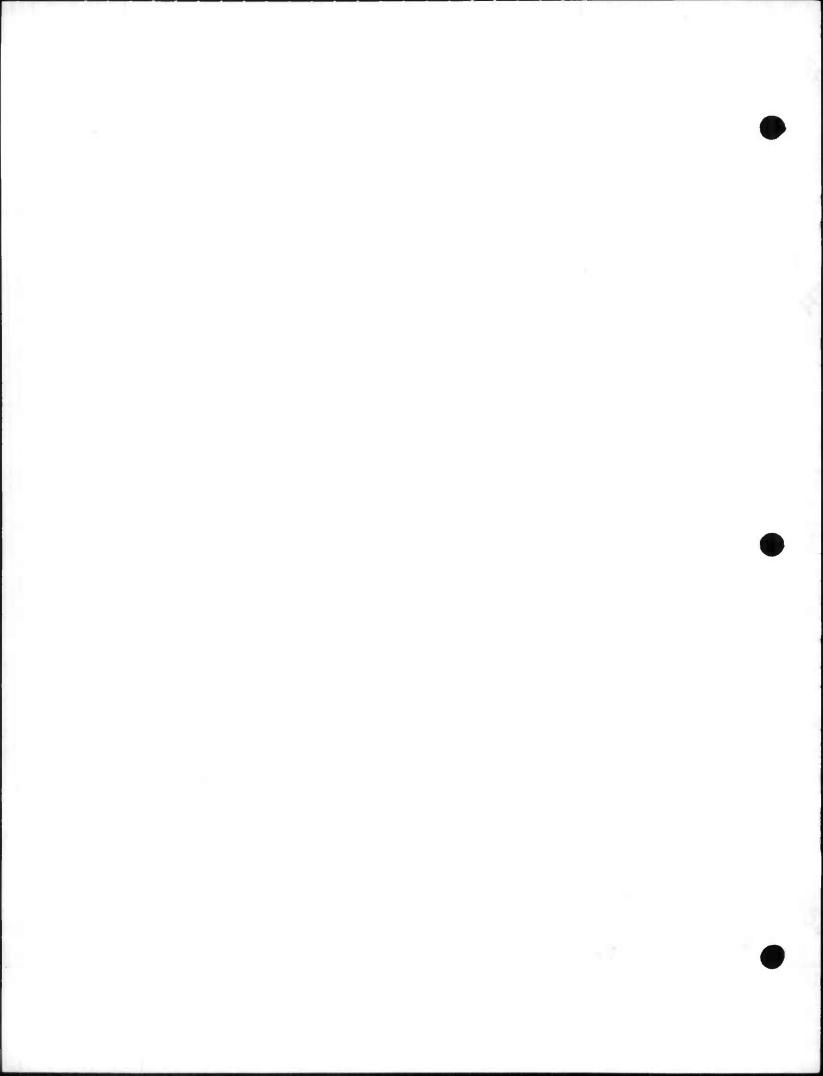
	1 - STATE REGISTRAR	STATE OF M	IARYLA		PARTM TIFICA				ME	NTAL HYGIEN		9	3 09837
	1. DECEDENT'S NAME (First, Middle, Last)					-			2.	DATE OF DEATH	AV	YEAR	3. TIME OF DEATH
	Mary Manko									04-02-	1993	TEAR	11:15pm™
	4. SOCIAL SECURITY NUMBER 233-30-9323	5. SEX	6. AGE (In	yrs. last birth	MONE	THE DAY	_	NDER 24 HRS.	7.	DATE OF BIRTH (Month, Day, Year)		Coun	HPLACE (State or Foreign try)
		1 🗆 M 2 💢 F		90 Y	RS.					(Month, Day, Year) 04-12-	V		ustria
DIRECTOR	9a. FACILITY NAME (If not inetitation, give s Francis Scott I		Cen	ter				TE (			9c. COI	INTY OF I	DEATH
ដ្ឋា	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNTY	Υ		100	c. CITY, TO	WN OR LO	CATION						10d. INSIDE CITY
E	Maryland					timo		itv					LIMITS?
	10e. STREET AND NUMBER						10f. ZIP (				10g. CI	TIZEN OF	WHAT COUNTRY?
EB	3501 Foster Aver	nue					212	24			Ur	nite	d STates
BY FUNERAL	11. MARITAL STATUS 1  Never Married 2  Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES	2 XNO		If yes,	specify (	NO Spe	can, P	ORIGIN? (Specify Yeuerto Rican, etc.)	s or No-	14. RAC Blac Spec	E - American Indian, ok, White, atc. c/ly: White
ED	15. DECEDENT'S EDU (Specify only highest grade	CATION		16a. DECEDE	NT'S USU	AL OCCUP	ATION			16b. KIND OF BU	SINESS/IN	DUSTRY	WITCO
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+	)		nd of work of NOT use reti		most or w	orung					
Š	17. FATNER'S NAME (First, Middle, Lest)	-					16. 1	OTNER'S	NAME (	First, Middle, Maiden	Sumame)		
BE	Michael Poleski				_			Anna	a .				
0	19a. INFORMANT'S NAME (Type/Print)									Number, City or Tow			
	John Manko							ing S	Str				MD 21224
	29a. METHOD OF DISPOSITION 1 Denation 8 Other (Specify)	oval from State	cemer S	tery, cremeton	y or other p	sposition lace) .aus (	(Name of Ceme	tery	4/10	6/93 Ba	cation – ltimo	OTE.	Maryland
	21. SIGNATURE OF FUNERAL SERVICE LIC	La S	ele.	nsk	bi	22. NAME	AND AD	DRESS OF	FACILIT	TY			omes MD 21224
	23. PART i. Enter the diseases, or called the shock, or heart failure.	complications that List only one cau	caused t	the death. ch line.	Do not e	nter the	mode of	dying, st	ich ac	cardiec or reap	iratory s	rest,	Approximate interval Between Onset and Death
	iMMEDIATE CAUSE (Final disease or condition resulting in death)	ABULT	PE	SPIRAT	ORY	DIS	TRES	5 SYN	DR	OME			G LIFEICS
	Tooling in South	DUE TO	(OR AS A C	CONSEQUEN									e weeks.
No	Sequentially list conditions,	. PNE	MON	CONSEQUENCE	OF OD.								
CERTIFICATION	if any, lesding to immediate cause. Enter UNDERLYING					- An /	TIA	10.1					
띪	CAUSE (Disease or injury that initiated events	C. DUE TO	OR AS A C	CONSEQUEN	CE OF):	MA	_110	10					
F	resulting in death) LAST	d											
	PART II. Other significant condition	e contributing to	donth but	t not requit	ting in th	a undad	des seu	na mhuan I	- D	4.1		Lav	
. ₽	GI BLEE		death but	t not readit	ung in un	e underij	ring cau	se given i	n Pan	t I. 24a. WAS AN PERFOI		24	b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC	DECUBITUS		<							1 🗆 YES 2	□ NO		OF DEATH?
Σ		OLLE R.										-1	1 YES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL					26.	PLACE (	F DEATH (	Check o	only one)			
Sic	EXAMINER?	HOSPITAL: 1   Inpatient 2	ER/Outpet	tient 3 🗆 Di		HER: Nursing N	lome 5	Residence	8 🗆	Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF (Month, Da		266	. TIME OF	28c.	INJURY A		_	d. DESCRIBE NOW	NJURY O	CURED	
BY F	1 Natural 5 Pending 2 Accident Investigation	(MONNY DO	-y, 10asy		MOON		YES	2 NO					
	3 Suicide 8 Could not be determined	28e. PLACE Of building,	F INJURY - etc. (Specify	— At home, fa	arm, street	, factory, o	ffice		28	f. LOCATION (Street City or Town, State)	and Numbe	r or Rural	Route Number,
COMPLETED		CIAN: To the best of a											s) and manner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIES		7) 0		gamon, m		-						
8	1 110	ask al	1120	Dona	02		29c.	LICENSE N	UMBER	9	29d. DA	TE SIGNED	D (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUS	C OF OFAT	HUTEM 27	(Type Print	1							

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detacted for up the filled within 72 hours after death with the State Dent, of Health and Mental Hydiene prior in burial, cremation, or removal	IMPORTANT: If hem 28 is marked, or fem 23 shows any injury, or other traumatic event, the medical examinar must be northead at once
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	FOR 1 - STATE	STATE OF N	MARYLAND /	DEPAR	TMENT OF	HEALTH A	ND M			E		
	REGISTRAR		CI	ERIIF	ICATE OF	DEATH	- 7		EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF D	DA	, , , , ,	VEAR	TIME OF OEATH
	Helen 4. SOCIAL SECURITY NUMBER				Neale					1993		1:30am •
		5. SEX	6. AGE (In yrs. las		IF UNDER 1 YEAR MONTHS DAYS	HOURS 24	MIN.	7. DATE OF B (Month, Day	(Year)		8. BIRTHPLAI Country)	CE (State or Foreign
	105-22-2911	1 🗆 M 2 🔀 F	85	YRS.				8/3	0/07		MD	
_	9a. FACILITY NAME (If not institution, give a	street end number)			9b. CITY, TOWN	OR LOCATION	OF DEAT	тн		9c. COUN	TY OF DEATH	
0	Maryland Gen	eral Host	oital			Balti	more	City				
5	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNT			T	Y, TOWN OR LOCA							
DIRECTOR	MD IOU. COOM	*		10c, CIT								INSIDE CITY
					BALTIMO							XYES 2 NO
FUNERAL	10s. STREET AND NUMBER				10	M. ZIP CODE				10g. CITIZ	EN OF WHAT	COUNTRY?
Ü	1041 BRANTEEYAA	VE.				21217				U.	S.A.	
15	11. MARITAL STATUS	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. AR	MED	13. WAS DE	CENDENT OF pecify Cuben,	HISPANIC	ORIGIN? (Se	ecify Yes	or No-	14. RACE — / Black, Wh	American Indian,
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES			2 NO		Poerto Hican	, etc.)	- 1	Specify:	me, arc.
	1	I										AMERICAN
	15. DECEDENT'S EDU (Specify only highest grade	completed)	16a, DE	CEDENT'S	VOINT OCCUPATE work done during m no retired.)	ON ost of working		16b. KIN	OF BUS	INESS/INDU	ISTRY	
1 2	Elementary/Secondary (0-12)	College (1-4 or 5 +	•)	. DO NOT US	recired.)			1				
COMPLETED												
	17. FATHER'S NAME (First, Middle, Last)					18. MOTHE	R'S NAME	E (First, Middle	, Melden S	Sumama)		
BE	GEORGE NEAL						_	STRU				
2	19a. INFORMANT'S NAME (Type/Print)		19		ADDRESS (Street						Code)	
	GERALDINE NEAL			1041	BRANTLE	EY AVE	BAL	TO. M	D 21:	217		
	20a. METHOD OF DISPOSITION 1   Burlal 2 □ Cremation 3 □ Rem	oval from State	cemetery, cre		OF DISPOSITION (N	ame of		DATE	20c. LOC	ATION — C	ity or Town, i	State
	4 Donation 5 Other (Specify)		ARBUT	US MI	EM. PARK		4/5/	93	AR	BUTUS	MD	
	21. SIGNATURE OP FUNERAL SERVICE LIK	CENSEE		1		NO ADDRESS			CD AT	HOME	D 4	
	Thurs MI	3616				P BRO						
	23. PART I, Enter the diseases, or	cómplicationa tha	caused the da	ath. Do r	ot enter the me	ode of dvino	n. such	as cardiac	or mapir	atory are	2121/ at 1	Approximate
	shock, or heart fellure.	List only one cau	se on each line	ı.		11923 116 116					2.0	Interval Between
	IMMEDIATE CAUSE (Final disease or condition	Conge	stive h	neart	failure	2					l	Onset and Death
	resulting in death)	a. DUE TO	(OR AS A CONSE	DUENCE OF	FI:							
1		Pleu:	ral effu	sion							j	
RTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	OR AS A CONSE	DUENCE OF	F):						i	
Į Į	cause. Enter UNDERLYING	Carcin	noma of	the								
Ē	CAUSE (Disease or injury that initiated events	G	101110 01	CHE	breast							
) E	that initiated events	DUE TO	OR AS A CONSE									
; E	resulting in death) LAST											
8	resulting in death) LAST	d	(OR AS A CONSEC	OUENCE OF	ק:							
8	resulting in death) LAST	d	(OR AS A CONSEC	OUENCE OF	ק:	g cause giv	ven in Pa	Ort I. 24e.	WAS AN A			IE AUTOPSY FINDINGS
8	resulting in death) LAST	d	(OR AS A CONSEC	OUENCE OF	ק:	g cause giv	ren in Pa			MED?	CON	LABLE PRIOR TO IPLETION OF CAUSE
8	resulting in death) LAST	d	(OR AS A CONSEC	OUENCE OF	ק:	g cause giv	ven in Pa		PERFORI	MED?	AMAI CON OF I	LABLE PRIOR TO
MEDICAL CE	resulting in death) LAST	d	(OR AS A CONSEC	OUENCE OF	ק:	g cause giv	ren in Pa		PERFORI	MED?	AMAI CON OF I	LABLE PRIOR TO IPLETION OF CAUSE DEATH?
MEDICAL CE	PART II. Other significant condition	d	(OR AS A CONSEC	OUENCE OF	r): in the underlyin	g cause giv		_   15	PERFORI	MED?	AMAI CON OF I	LABLE PRIOR TO IPLETION OF CAUSE DEATH?
MEDICAL CE	PART II. Other significant condition	d	(OR AS A CONSEC	OUENCE OF	in the underlyin	LACE OF DEA	TH (Check	1 [	PERFORI	MED?	AMAI CON OF I	LABLE PRIOR TO IPLETION OF CAUSE DEATH?
MEDICAL CE	PART II. Other significant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	death but not r	DUENCE OF PERSONNEL OF PERSONNE	28. P OTHER: 4   Nursing Hon	LACE OF DEA	TH (Check	1 [	PERFORI YES 2	MED?	AMAI CON OF I	LABLE PRIOR TO IPLETION OF CAUSE DEATH?
PHYSICIAN: MEDICAL CE	PART II. Other significant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending	d. a contributing to	death but not r	DUENCE OF PERSONNEL OF PERSONNE	28. P OTHER: 4 □ Nursing Hon E OF 28c. IN. WY W	LACE DF DEA	TH (Check	t only one)	PERFORI YES 2	MED?	AMAI CON OF I	LABLE PRIOR TO IPLETION OF CAUSE DEATH?
BY PHYSICIAN: MEDICAL CE	PART II. Other significant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 VES 2 NO  27. MANNER OF DEATH	HOSPITAL: 1	death but not r  ER/Outpatient 3 INJURY ny, Year)  FINJURY — At ho	ovence of resulting if	28. P OTHER: 4 □ Nursing Hon E OF 28c. IN. WY W	LACE DF DEA	TH (Check	Nonly one) Other (Spe	PERFORI  YES 2  HOW IN	MED?  NO  NO  JURY OCCI	AMAI CON OF I	LABLE PRIOR TO PIPLETION OF CAUSE DEATH?  YES 2  NO
ED BY PHYSICIAN: MEDICAL CE	PART II. Other significant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation	HOSPITAL: 1	death but not r  ER/Outpatient 3 INJURY INJURY	ovence of resulting if	28. P OTHER: 4   Nursing Hon E OF 28c. IN. WRY M 1	LACE DF DEA	TH (Check	k only one)  Other (Spe	PERFORI  YES 2  HOW IN	MED?  NO  NO  JURY OCCI	AMAI COM OF I	LABLE PRIOR TO PIPLETION OF CAUSE DEATH?  YES 2  NO
ED BY PHYSICIAN: MEDICAL CE	PART II. Other significant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5 Pending Investigation  2 Accident 3 Suicide 6 Could not ba determined	HOSPITAL: 11/2 Impetient 2 28a. DATE OF (Month, Debuilding,	death but not r  ER/Outpatient 3 INJURY ny, Year)  F INJURY — At ho etc. (Specify)	DOA TIME	28. P OTHER: 4 Nursing Hon E OF 28c. IN. URY M 1 1	LACE DF DEAT	ATH (Check dence 6 2 NO	Nonly one) Other (Special Descried Descried City or Town	PERFORI  YES 2  Incity)  E HOW IN  I (Street error, State)	JURY OCCI	JRED	LABLE PRIOR TO PIPLETION OF CAUSE DEATH?  YES 2  NO
ED BY PHYSICIAN: MEDICAL CE	PART II. Other significant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined  29e. CERTIFIER (Check only 1 CERTIFVING PHYSI	HOSPITAL:  1½ Impatient 2  28a. DATE OF (Month, Do building,	death but not r  ER/Outpatient 3 INJURY ny, Year)  F INJURY — At ho etc. (Specify)  my knowledge, de	DOA TIME	28. P OTHER: 4 Nursing Hon E OF 28c. IN. WY M 1 1	LACE DF DEAT	NO 2	Other (Special Description City or Tow	PERFORI  YES 2  Incify)  E HOW IN  I (Street error, State)  end maner	JURY OCCI	JRED JRED d.	LABLE PRIOR TO PILETION OF CAUSE SEATH?  YES 2 \( \sum \) NO  Number,
COMPLETED BY PHYSICIAN: MEDICAL CE	PART II. Other significant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5 Pending Investigation 3 Suicide 6 Could not ba determined  29e. CERTIFIER (Check only one)  2 MEDICAL EXAMINE	HOSPITAL: 11/2 Impatient 2 28e. DATE OF (Month, De building,	death but not r  ER/Outpatient 3 INJURY ny, Year)  F INJURY — At ho etc. (Specify)  my knowledge, de	DOA TIME	28. P OTHER: 4 Nursing Hon E OF 28c. IN. WY M 1 1	LACE DF DEA	NO 2	Other (Special Description of the cause(e) me, data and	PERFORI  YES 2  Incify)  E HOW IN  I (Street error, State)  end maner	JURY OCCI	JRED  W Rural Route  d, cause(e) and	LABLE PRIOR TO PILETION OF CAUSE DEATH?  YES 2 NO  Number,
ED BY PHYSICIAN: MEDICAL CE	PART II. Other significant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined  29e. CERTIFIER (Check only 1 CERTIFVING PHYSI	HOSPITAL: 11/2 Impatient 2 28e. DATE OF (Month, De building,	death but not r  ER/Outpatient 3 INJURY ny, Year)  F INJURY — At ho etc. (Specify)  my knowledge, de	DOA TIME	28. P OTHER: 4 Nursing Hon E OF 28c. IN. WY M 1 1	LACE DF DEAT	NO 2  Ind due to left the times SE NUMBER	Other (Speed DESCRIBE LOCATION City or Tou	PERFORI  YES 2  Incify)  E HOW IN  I (Street error, State)  end maner	JURY OCCI	JRED  W Rural Route  d, cause(e) and	LABLE PRIOR TO PILETION OF CAUSE SEATH?  YES 2 \( \sum \) NO  Number,
BE COMPLETED BY PHYSICIAN: MEDICAL CE	PART II. Other significant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 VES 2 NO  27. MANNER OF DEATH  1 Natural 5 Pending Investigation 3 Suicide 6 Could not ba determined  29. CERTIFIER (Check only one) 2 MEDICAL EXAMINER  29b. SIGNATURE AND TITLE OF CENTIFIER	HOSPITAL: 1	death but not r  ER/Outpatient 3 INJURY 9, Year)  FINJURY — At ho etc. (Specify)  my knowledge, de	DOA DOA 28b. TIMINJ me, ferm, s	28. P OTHER: 4 Nursing Hon E OF 28c. IN URY M 1 1 street, factory, office	LACE DF DEA	NO 2  Ind due to left the times SE NUMBER	Other (Special Description of the cause(e) me, data and	PERFORI  YES 2  Incify)  E HOW IN  I (Street error, State)  end maner	JURY OCCI	JRED  W Rural Route  d, cause(e) and	LABLE PRIOR TO PILETION OF CAUSE DEATH?  YES 2 NO  Number,
E COMPLETED BY PHYSICIAN: MEDICAL CE	PART II. Other significant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 VES 2 NO  27. MANNER OF DEATH  1 Natural 5 Pending Investigation 3 Suicide 6 Could not ba determined  29e. CERTIFIER (Check only One) 2 MEDICAL EXAMINE  29b. SIGNATURE AND XITLE OF CERTIFIER  30. NAME AND ADDRESS OF PERSON WH	HOSPITAL: 1	death but not r  ER/Outpatient 3 INJURY INJURY — At ho etc. (Specify)  my knowledge, de	DOA DOA 28b. TIMINJ me, ferm, s	28. P OTHER: 4 Nursing Hon E OF 28c. IN URY M 1 1 street, factory, office	LACE DF DEA	NO 2 nd due to l at the tin	Other (Special Description of the cause(e) one, data and the cause(e) of the c	PERFORI  YES 2  A (Street erry, State)  end many	JURY OCCI	JRED  W Rural Route  d, cause(e) and	LABLE PRIOR TO PILETION OF CAUSE DEATH?  YES 2 NO  Number,



ITEMS: 23 PART I, 27, 28a-f, PER MEO G-698 4/8/93 t.t

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 IMPORTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

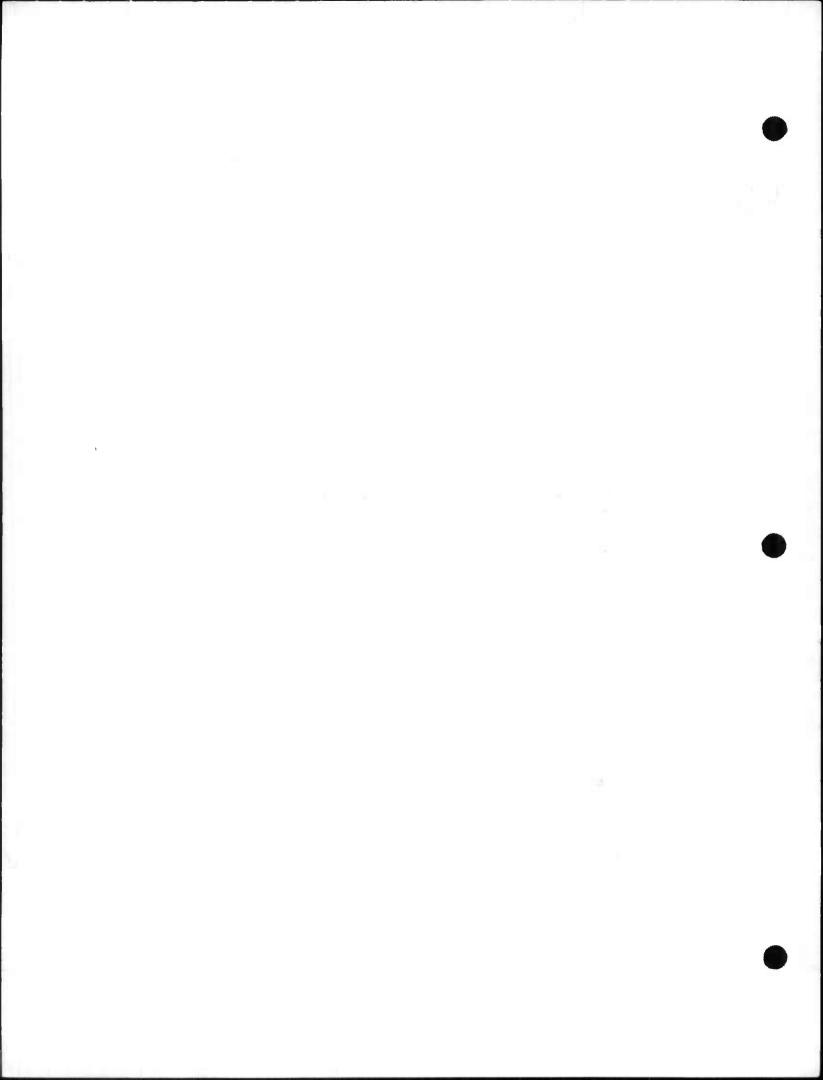
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR 1 - STATE REGISTRAR	STATE OF MARY	LAND / DEPARTA CERTIFIC			MENTAL HYG			
1. DECEDENT'S NAME (First, Middle, Last) ROBERT	G.	PEACHEI	2		2, DATE OF DEA M9NTH 2			3. TIME OF DEATH 5:00 P
4. SOCIAL SECURITY NUMBER	1 🖾 M 2 🗆 F 3		UNDER 1 YEAR NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRT (Month, Day, Ye 3-13-1	ar)	8. BIRTNP Country)	LACE (State or Foreign
98. FACILITY NAME (If not institution, give s 2209 liberty RESIDENCE OF DECEDENT				OR LOCATION OF DE		9c. COU	NTY OF DE	ATN
-	y na		own on Loca imore	TION				IOd, INSIDE CITY LIMITS?
3553 Buenavista				t, ZIP CODE			ZEN OF WH	AT COUNTRY?
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR I	2 NO	If yes, s	CENDENT OF HISPAN becify Cuban, Maxica 5 2 NO Specify	n, Puerto Rican, ate		14. RACE - Black, Specify	- American Indian, White, atc. White
15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	16a. DECEDENT'S USI (Give kind of work life. Do NOT use re	done during m	ON ost of working	16b. KIND O	F BUSINESS/IND	USTRY	
17. FATNER'S NAME (First, Middle, Last)				18. MOTNER'S NA	ME (First, Middle, M	alden Surname)		
19a. INFORMANT'S NAME (Type/Print)  OCIME		19b. MAILING AD	DRESS (Street	and Number or Rural F	Route Number, City o	r Town, State, Zip	Code)	
20e. METNOD OF DISPOSITION 1 Burlal 2 Cremation 3 Rem 4 Donation Other (Specific Line)	oval from Style Cel	b. PLACEAND DATE OF D matery, cremetory or other val	plece)			c. LOCATION —		1 7100
21. SIGNATURE OF FUNERAL SERVICE LIC	Ronald W	lade, Dir	22. NAME A	nd address of fac	State St,Bal	Anator	my Bo 21201	ard
MMEDIATE CAUSE (Final	a. ACUTE NARC	eech line.				respiratory arm	eat,	Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	ć	A CONSEQUENCE OF):						
PART ii. Other algnificent condition	a contributing to deeth t	but not resulting in t	he underlyin	g cause given in	PE	S AN AUTOPSY RFORMED?	6	VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE F DEATH?  YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 X YES 2 \( \text{NO} \) NO	HOSPITAL: 1   Inpetient 2   ER/Out		THER:	LACE OF DEATH (Che		2209 I	LIBE	RTY HGHTS
EXAMINER?	1 Inpetient 2 ER/Out  28a. DATE OF INJURY (Month, Day, Year)  Found: 3 - 2	28b_TIME OF INJURY  5 - 9 3 4 : 4 5  Y — At home, farm, stree	FHER: Nursing Hon 28c. IN. WC	Ne 5 Residence NURY AT NRK? YES 2 NO	28d. DESCRIBE H UNKNOWN 281. LOCATION (Si City or Town, Si	ow injury occurred and Number State) 2 2 0 9	or Rural Roo	ne Number, rty Heights
EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural Investigation 2 Accident 3 Suicide 8 Could not be determined  29a. CERTIFIER (Check only) 1 CERTIFYING PNYSH	1 Inpetient 2 ER/Out 28a. DATE OF INJURY (Month, Day, Year) Found: 3 = 2 28a. PLACE OF INJURY building, etc. (Spe	280 TIME OF INJURY 5-93 4:45 Y — At home, farm, streechy ARTMENT	THER:   Nursing Hon   28c. IN, W   1       1, factory, office	Ne 5 Rasidence NURY AT NRK? YES 2 NO	Other (Specify 28d. DESCRIBE H UNKNOWN 28f. LOCATION (Si City or Yown, A Ave. Bal to the cause(s) and	ow injury occurred and Number State) 2 2 0 9 timore,	or Rural Roo Libe Mar	ne Number rty Heights yland
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31. DATE FILED (Month, Day, APR



DIVISION OF VITAL RECORDS, P.O. BOX 68760,	BIGING PHYSICIAN: The law requires that the death certificate be executed within
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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 5- 1993 YEAR MONTH 4 Joseph R. Perkins 4. SOCIAL SECURITY NUMBER f. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Fo J X 216-10-5494 d YRS. 1 2 dionth, Day glear) Balto., Md. 72 HOURS 1918 Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, sive stress end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH DIRECTOR Mercy Medical Center Baltimore RESIDENCE OF DECEDENT 10b. COUNTY 19c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Md. Baltimore Dundalk 1 YES 2 X NO permit. FUNERAL 100. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6813 Dunhill Rd. 21222 use as the burial-transit U.S.A. 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 12. WAS OECEDENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-1 Never Married 2 X Married If yes, specify Cuban, Mexican, Puerto Ri 1 YES 2 NO Specify: BY 3 Widowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16b. KIND OF BUSINESS/INDUSTRY funeral director, page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) 11 yrs Molder Steel Mfg. once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) William Perkins notified at Elizabeth Roberts BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) Veronica Perkins 6813 Dunhill Rd., Dundalk, Md. 21222 2 20a. METHOD OF DISPOSITION

1X Pourlai 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must Oak Lawn Cemetery 4-8-93 4 ☐ Donation 5 ☐ Other (Specify) Balto., Md. 21. SIGNATURE OF FUNERAL SERVICE LIGHT examiner 22. NAME AND ADDRESS OF FACILITY 21222 Peter S. Ashton Bradley-Ashton Funeral Home, Inc. 2134 Willow Spring Rd., Dundalk, Md ed in by the fi M00011 event, the medical 23. PART i. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cerdiec or raspiratory arrest, certificate has been signed by the attending physician and completely filled in by 'n the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remo Approximate interval Between shock, or heart failure. List only one cause on sech line. **IMMEDIATE CAUSE (Fine) Onset and Death** disease or condition resulting in death) bao Corcinoura traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF cause. Enter UNDERLYING CAUSE (Disease or injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditione contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS Avenie AVAILABLE PRIOR TO shows any COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 NO Huser PHYSICIAN: 23 Item 2 26. PLACE OF DEATH (Check only one OTHER: 1 YES I DIG lent 2 D ER/Outpettern 3 D DOA 0 27, MANNEN OF DEATH DATE OF INJURY (Month, Day, Year) 284. DESCRIBE HOW INJURY OCCURED 26b. TIME OF 28c. INJURY AT WORK? After this co marked, 1 YES 2 NO BY 28s. PLACE OF INJURY -- At home, farm, street, factory, office . 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number City or Taxon, State) BE COMPLETED 6 Could not be OUS APER 4 🗌 Homicide 28 them 29a, CERTIFIER CESTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated. 2 MEDICAL EXAMINER: On the basic of exam death occured at the time, date and place, and due to the cause(e) and manner as stated N Her Como 6 6 9 M 53 2 Jan ELDMAN,

22. REGISTRAR'S SIGNATURE relia Davidson

A spirit freet and the second SOUND THE THE WAY TO DESCRIPT TO STREET, N. CO. S. P. LEWIS CO TO BE COMPLETED BY FUNERAL DIRECTOR

BALTIMORE, MARYLAND 21215-0020

- STATE REGISTRAR													
1. DECEDENT'S NAME (First, Middle, Last)							DATE OF DE	ATH			3. TIME OF DEA	TH	
ETHEL			PAUGH			1	0 4	0 3	190	YEAR	3:20	ДМ	
217 52 0771	5. SEX 6. /	AGE (In yrs. le:		FUNDER 1 YEAR FUNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 7 2 191					8. BIRTHPLACE (State or Foreign				
9e. FACILITY NAME (If not institution, give street	et and number)		98	. CITY, TOW	N OR LOCATION OF	DEATH			c. COUN	TY OF D	EATH	15	
609 PARK AVENU	E			BALT	IMORE								
Maryland 10b. COUNTY				own or Lo							10d. INSIDE CIT LIMITS? 1 X YES 2		
10e. STREET AND NUMBER					10f. ZIP CODE			1	0g. CITIZ	EN OF V	WHAT COUNTRY?		
3524 Roland Ave	•				2121	1				U.S	.A.	H	
11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	Never Married 2 Married FORCES? 1 YES 2				NO If yes, specify Cuben, Mexican, Puer								
15. DECEDENT'S EDUCAT (Specify only highest grade co	TION empleted)	/G	ECEDENT'S US	done during	ATION most of working		18b. KIND	OF BUSIN	ESS/INDU				
Elementary/Secondary (0-12) 8 years	College (1-4 or 5+)	life	. Do NOT use re	e kind of work done during most of working Do NOT use retired.)  Aitress Jimmy's Se					Sea	eafood			
17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S N	AME (F	First, Middle, I	Meiden Su	neme)		-		
James Robert	Archer						Bar						
19a. INFORMANT'S NAME (Type/Print)					et end Number or Rura								
Anna Smith					d Ave. E								
1 Burial 2 Cremation 3 Ramovi	at from State	cemetery, cre	AND DATE OF C imatory or other LaWn	nlecel	tery 4/6	- 1					wn, State	]	
Cotherine	In Bo	' 0 .		100	AND ADDRESS OF F		0	,			- 9 -110		
23. PART I. Entar tha diseasea, or cor ahock, or haart failure. Lis IMMEDIATE CAUSE (Final disease or condition	st only one cause o	on aach lina	n	antar tha	1						2 1 2 3 1 Approximintarval B Onset an	etween	
IMMEDIATE CAUSE (Final	SMOK!	AS A CONSEC	OUENCE OF):	antar tha	moda of dying, au						Approxim	etween	
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32. RECISTRAR'S SIGNATURE

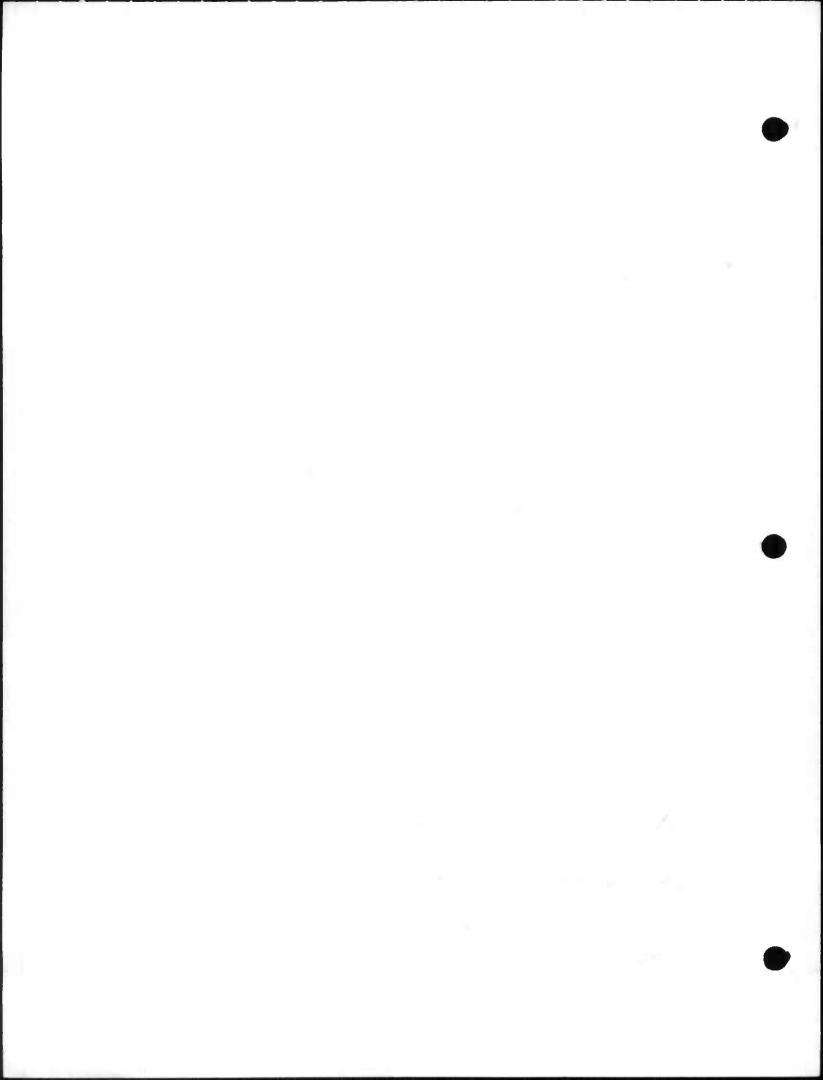
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trabe filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

31. DATE FILED (Month, Day,

1993

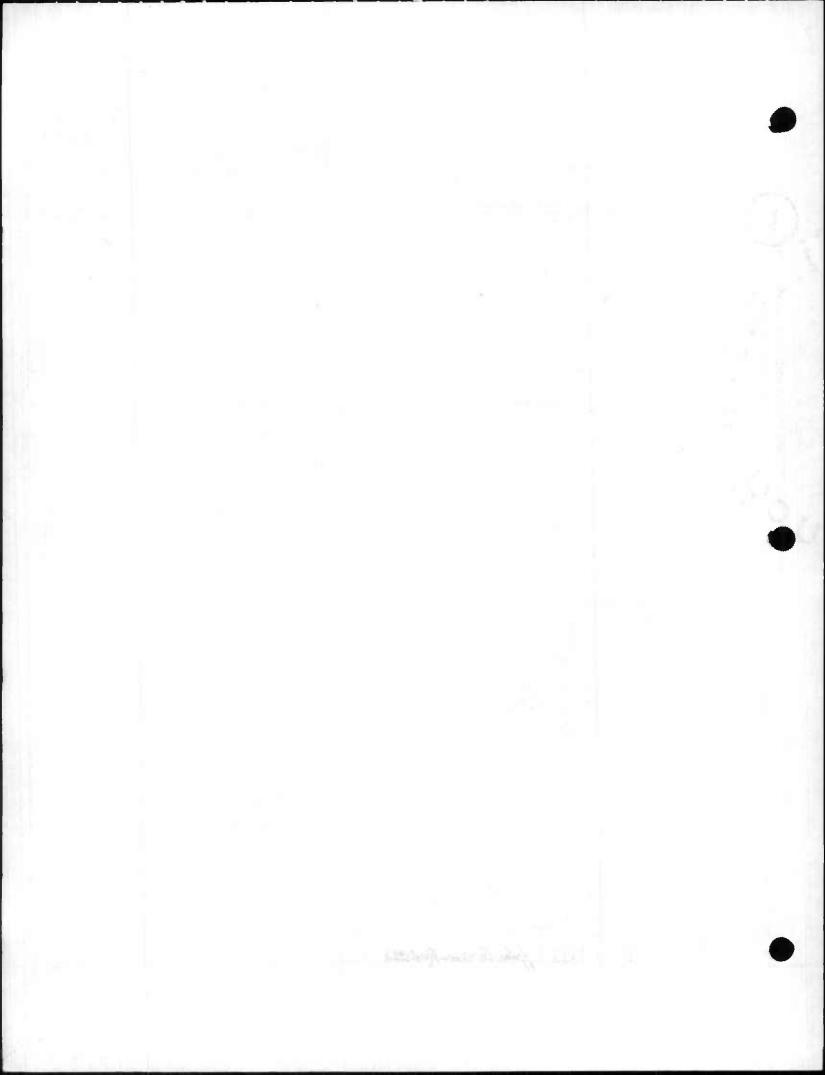
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



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	1 - STATE REGISTRAR	STATE OF MARYLA		TIMENT OF			IENTAL HYGIE! REG. NO				
	1. DECED ME (First, Middle, Last)		02,111	TOAT E	DEA		2. DATE OF DEATH		3. TIME OF DEATH	-	
	MATHIAS G.	PFISTER					монти 3	WY 3/	93 805	AN	
			yrs. lest birthday)	IF UNDER 1 YEA			7. DATE OF BIRTH		BIRTHPLACE (State or Forei	gn	
	216 -03 -3814 1	ØM2□F	YRS.	MONTHS DAY	HOURS	MIN.	(Month, Day, Year)	/1915	MD .		
	9s. FACILITY NAME (If not institution, give street		9b. CITY, TOW	OR LOCATI	ON OF DEA	АТН	9c. COUNT	Y OF DEATH			
O. H	VETERANS, MEDICAL	CENTER		Bal	timo	re	*	1	ity		
	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNTY	10c CIT									
DIRECTOR	MD.	100.01					10d. INSIDE CITY LIMITS?				
	10. STREET AND NUMBER		BALT	O .			I too CITIZE	1 YES 2 NO	)		
N S	330 RADNOR AVE.										
I N		. WAS DECEDENT EVER IN	II S. ADMED	12 480 0		1212		U.S.A.  GIN? (Specify Yea or No.   14, RACE - American			
BY FUNERAL	1 Never Married 2 Married 3 Widowed 4 Divorced	2 NO	If yes,		in, Maxican,	, Puerto Rican, atc.)					
	15. DECEDENT'S EDUCATI	ON	16a. DECEDENT'S				16b. KIND OF BU	ISINESS/INDUS		_	
COMPLETED	(Specify only highest grade com Elementary/Secondary (0-12) C	ollege (1-4 or 5+)	(Give kind of life. Do NOT us	work done during se retired.)	nost of working	ng	1.00				
Ĭ ₫	12yrs		IMPR	OVEMEN	TS		Р	AINTE	R		
CON	17. FATHER'S NAME (First, Middle, Last)					HER'S NAM	E (First, Middle, Maider				
6 111	MICHAEL PFIST	ER				MAR	Y BACKE	RT			
TO BE	19a, INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	t and Number		oute Number, City or Tov		ode)	_	
	HELEN PFISTER		3	30 RAD	NOR	AVE.	BALTO.	. MD.	21212		
	20s. METHOD OF DISPOSITION  1 M. Burlal 2 Cremation 3 Removal		PLACE AND DATE	OF DISPOSITION					y or Town, State		
	4 Donation 5 Other (Specify) ST MARYS CEM. 4/3 BALTO, CITY										
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY										
a de la composition della composition della comp	HENRY W. JENKINS & SONS CO.										
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
	IMMEDIATE CAUSE (Final									aath	
	resulting in death)  a. As piration										
		DUE TO (OH AS A	CONSEQUENCE O	F):							
No	Sequentially list conditions, b	Sequentially list conditions.									
RTIFICATION	if any, leading to immediate										
문	CAUSE (Disease or Injury										
	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST										
CE	d										
	PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED?									INGS	
MEDICAL	Preumonia							PERFORMED?  1 YES 2 NO OF DEATH?			
W	Dementia										
									1 NES 2 NO		
×	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			26.	PLACE OF D	EATH (Chec	k only one)				
Sic		OSPITAL:  Inpatient 2 - ER/Output	lent 3 DOA	OTHER:	me 5 🗆 Ra	sidence 8	Other (Specify)				
PHYSICIAN:	27. MANNER OF DEATH		28b. TIME OF 28c. INJURY AT 28d. D				DESCRIBE HOW INJURY OCCURED				
ВУР	1 Natural 5 Pending	YES 2	NO								
	2 Suiside	2 Accident  3 Suicide 28s. PLACE OF INJURY — At home, farm, street, factory, office 28s. LC							Rural Route Number,		
	4 Homicide datarmined	Dullding, etc. (Specify)									
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of an including the control of the best of an including the control of the best of an including the control of the best of an including the control of the best of an including the control of the best of an including the control of the best of an including the control of the best of an including the control of the best of an including the control of the best of										
M	298. CERTIFIER  (Check only one)  CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.  MEDICAL EXAMINER: On the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.										
	29b. SIGNATURE AND TITLE OF CERTIFIER				,					nd.	
BE	1/1/10/10/11/11	im			29c. LICE	NSE NUMB	ER	29d, DATE S	IIGNEO (Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)								131115		
	Rul + 1/Ama	16 S	Green	o Ret	-,		2120				
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNAT		JV.							
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DHMH-18 Rev 1/89



BALTIMORE, MARYLANI	TO THE HOSPITAL OF ATTENDED TO THE LAW requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTURE After the factor has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after county with 12 hours.	IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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DIVISION WITH RECORDS, P.O. BOX 68760,	d withi	TO THE FUNERAL DIRECTUR AND COMPLETE has been signed by the attending physician and completely filled in by the for the first within 72 hours, after count, with the State Deat, of Health and Mental Hogiene prior to burial, cremation, or removal.	event
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_	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
	1. decedent's name (First, Middle, Last) Nathan	M.	Porte	er, Jr.		2. DATE OF DEATH DO ADYIL 3,	1993 YEAR	3. TIME OF DEATH 7:20 A.M M			
	216_16_8471	1)XXM 2 - F	71 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Morith, Day, Year) October 8	8. BIR	mHPLACE (State or Foreign arry)			
TOR RO	9a. FACILITY NAME (If not institution, give stre 1167 Nanticoke				t imore		9c. COUNTY OF DEATH Baltimore, City				
DIRECTOR	10a. STATE 10b. COUNTY	Itimore City		Y, TOWN OR LOCAT	Baltir	nore	10d. INSIDE CITY LIMITS? 1 X YES 2 NO				
FUNERAL	100. STREET AND NUMBER 1167 Nanticoke		101	ZIP CODE 212			F WHAT COUNTRY?				
BY	11. MARITAL STATUS 1 Never Married 2 W Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 X YES IF YES, GIVE WAR OR DO NOT DOWN TO THE WORLD	2 NO ATES	If yes, sp		HC ORIGIN? (Specify Yee n, Puerto Rican, etc.)	or No- 14. RA	CE - American Indian, ack, White, etc.			
15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)  12  17. FATHER'S NAME (First, Middle, Lest)  18. MOTHER'S NAME (First, Middle, Medicen Surname)											
MP	12			Salesma			Bakery				
BE CO		1.	Porter	Sr.	Irma	ME (First, Middle, Maiden  I •	Irela	ınd			
TO 1	190. INFORMANT'S NAME (Type/Print)  Diane Williams		4			Baltimore		21230			
	20a. METHOD OF DISPOSITION 1   Burlel 2   Cremation 3   Remov	al from State 20b	PLACE AND DATE	OF DISPOSITION (Na		DATE 20c LO	cation — chy or altimore				
	21. SIGNATURE ON FUNERAL SERVICE LICEY	lunuw	.oudon 11	MCCU	lly Fune	ral Home or	f Brookl	yn 21225			
CERTIFICATION	23. PART I. Enter the diseases, or conshock, or heart failure. List immediate CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A	sch iina.	NOMA TO BRAIN WILLEAR ETTOLICY SMANNS							
MEDICAL	PART II. Other significant conditions	In the underlying	g cause givan in	Part I. 24a. WAS AN. PERFOR 1 TYES 2	MED?	4b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO					
PHYSICIAN:		HOSPITAL:		OTHER:	ACE DF DEATH (Che						
НХВ	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIM	E OF 28c, INJ	URY AT	6 Other (Specify)  28d. DESCRIBE HOW III	JURY OCCURED				
ВУР	1 Natural 5 Pending Accident Investigation	(Month, Day, Year)	IN.		RK? 'ES 2 NO	20.00. 20.000					
3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number of Rural Route Number or Route Number or							l Route Number,				
COMPLET	29a. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIA 2 MEDICAL EXAMINER:	AN: To the best of my knowl On the basis of examination	edge, death occurr and/or investigation	ed at the time, date on, in my opinion, d	and place, and due	to the cause(s) and man	ner as stated,	r(a) and manner sa stated,			
BE	29b. SIGNATURE AND TITLE OF CERTIFIED	· W			29c. LICENSE NUM	BER	29d. DATE SIGNE	ED (Month, Day, Year)			
10	30. NAME AND ADDRESS OF PERSON WHO CO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type	Print) Print)	E MARV	IANO H	SP MAR	-/			
	APR 07 1993	32 REGISTRAR'S SIGNA	ATURE Panders	.,,	- 1-11		77/-				

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hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	OD ATTENDING DUVELCIAM. The law secures that the death certificate he assessed within 12.9
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31. DATE FILED (Month, Day, Year)

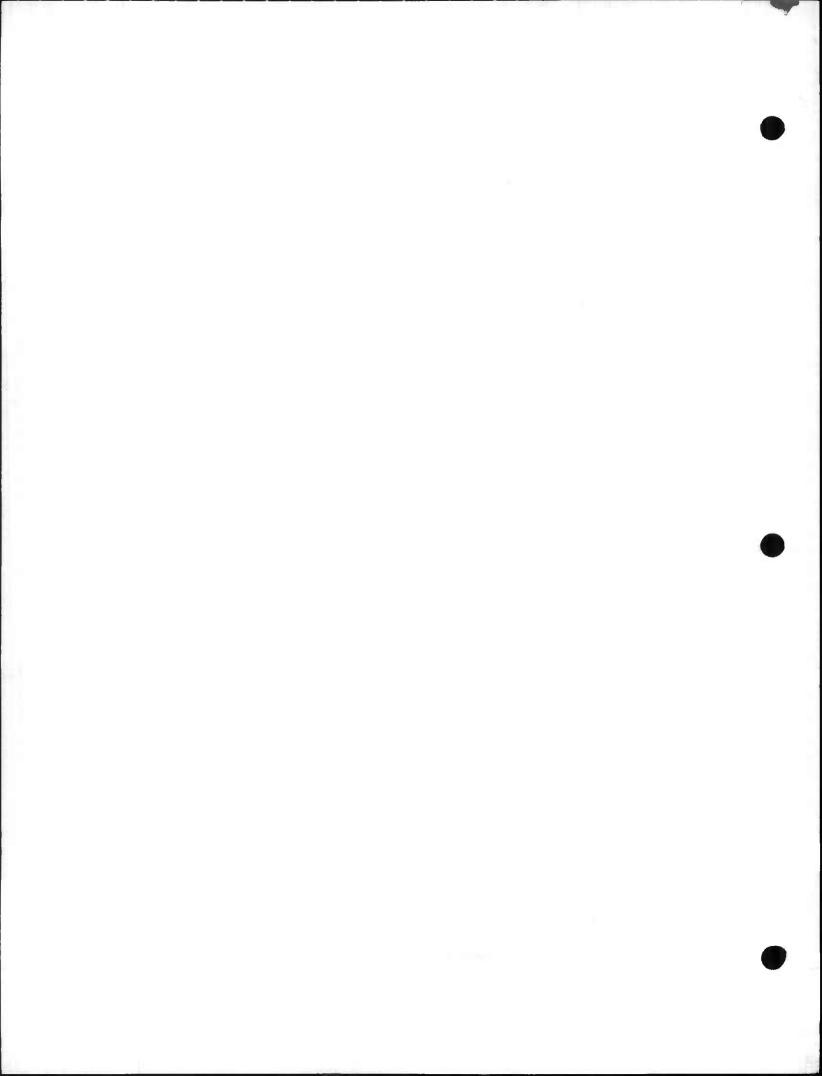
APR 07 1993

32. REGISTRAR'S SIGNATURE

his Davidson Pandall

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH APRIL 3, 1993 YEAR AUDREY QUEEN Р. м 2:45 A SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 4-11-50 214-54-1213 1 M 2 XF 42 MD use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH MARYLAND GENERAL HOSPITAL DIRECTOR BALTIMORE, CITY RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY BALTIMORE, MARYLAND MARYLAND 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2312 Ashland Ave. 21205 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—if yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 HO Specify: 14. RACE — American Indian, Black, White, etc. 2 NO 1 YES 1 Never Married 2 Marrie IF YES, GIVE WAR OR DATES 路 3 Widowed 4 Divorced Black COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY þ Elementary/Secondary (0-12) College (1-4 or 5+) 12th detached Disabled 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) John Henry Queen page 5 should be Ħ Pearl Harris BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Agnes Watkins 8240 Church Ln. Apt.G/Baltimore, MD21207 Pe 20a, METHOD OF DISPOSITION
1 Description | METHOD OF DISPOSITION | 3 Per | Receipt | 4 Denation | 5 Other (Specify) | 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State director, must Mount Zion Cemetery ansdowne, 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY the funeral filled in by the fi WM C. MARCH F.H./1101 E. NORTH AVE. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between shock, or heart failure. List only one cause on each line IMMEDIATE CAUSE (Final **Onset and Death** physician and completely fille one prior to burial, cremation, or other traumatic event, the disease or condition resulting in death) METASTATIC CERVICAL CARCINOMA DUE TO (OR AS A CONSEQUENCE OF): RESPIRATORY FAILURE CERTIFICATION Sequentially tlat conditions, DUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury CHRONIC RENAL FAILURE DUE TO (QR AS A CONSEQUENCE OF): that initiated events the attending if Mental Hygien resulting in death) LAST Hem 23 shows any injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL signed by t 1 TYES 2 NO OF DEATH? 1 TES 2 NO certificate has been h the State Dept. of H PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL OTHER: 1 | YES 2 | NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA e 5 Residence 6 Other (Specify) 6 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF with t 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED is marked. 1 Natural 5 Pending Investigation M 1 YES 2 NO death w B 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED FUNERAL DIRECTOR: within 72 hours after 28 4 Homicide 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL
TO THE FUNERAL I
BE filed within 72 h
IMPORTANT: If II 2 \_ MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE. mys Shiwan n/a 4/3/93 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) / C/O Maryalnd General Hospital



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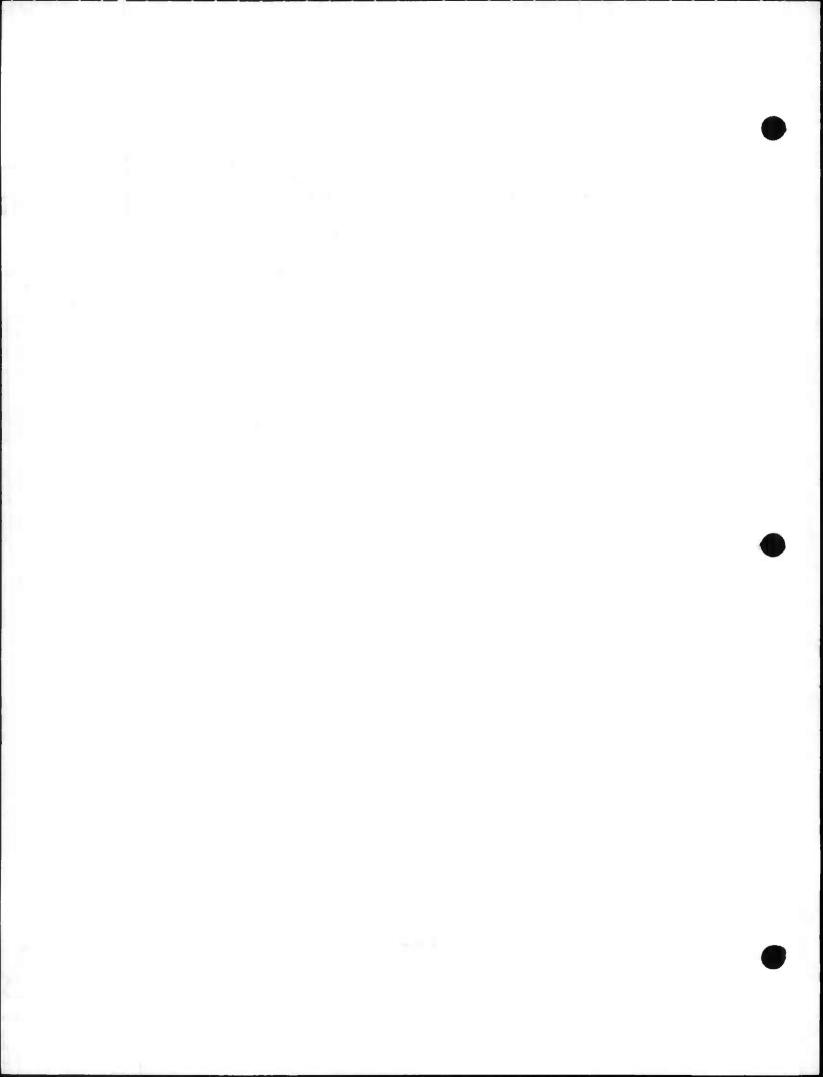
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1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH eid VIOLET E. REIDY rolet 1/35Am 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH 6. AGE (In vrs. 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. Dec. 24,1902 216-07-3762 90 1 M 2 F Maryland use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Good Samaritan Hospital Baltimore RESIDENCE OF DECEDENT 10b. COUNT 10c CITY TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Baltimore Baltimore Maryland 1 YES 2 NO FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1801 Wentworth Road 21234 U.S.A. retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS OECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married IF YES GIVE WAR OR DATES 1 YES 2 NO Specify: ВУ 3 Widowed 4 Divorced Specify: White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KINO OF BUSINESS/INDUSTRY (Specify only high jo Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home detached 6 Once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) 2 ¥ Frederick H. Wasmus Rebecca N. Wilder BE director, page 5 should notified 19e, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Doris N. Myers 1105 Dulaney Gate Circle, Cockeysville, Md. 21030 nours after death. Page 6 may be 9 20s. METHOD OF DISPOSITION

| Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | Grant | 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must Parkwood Cemetery 4-6-93 Parkville, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY the funeral · Wallac Ruck Towson Funeral Home, Inc. filled in by the fon, or removal. 1050 York Road, Towson, Md. 21204 medical 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line interval Betwe IMMEDIATE CAUSE (Final **Onset and Death** or other traumatic event, the cremation. disease or condition resulting in death) Towe 7days rysician and completely prior to burial, crematic Condiquescular Meriosclerche CERTIFICATION Sequentially list conditions, ue to thysician and Hygiene price DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST attending Mental 1 Item 23 shows any injury, PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. the 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL signed by the Wellitus 1 TYES 2 T NO OF OEATH? 1 TYES 2 NO L. of I has be Dept. PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) State **sertificate** HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 YES 2 NO e 5 - Residence 8 - Other (Specify) 4 - Num the 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) a file 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE NOW INJURY OCCURED is marked, 1 Natural 5 Pending Investigat 1 YES 2 NO After 13 death v BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED DIRECTOR hours after 82 4 Homicide Hem 29e. CERTIFIER (Check only one)

One)

MEDICAL EXAMINED, On the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and menner as stated. FUNERAL I Within 72 h = 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death TO THE HOSPITA
TO THE FUNETA
De filed within T occured at the time, date and place, and due to the cause(e) end menner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE BIGINED (Mingh. Day. BE LICENSE NUMBER 1942 2 DENTRYTEM 27) (Type, Byrl)
Balto, Wal 21239 MA ADDRESS OF PERSON WHO COMPLETED CAUSE PI 5601 O6\*1993



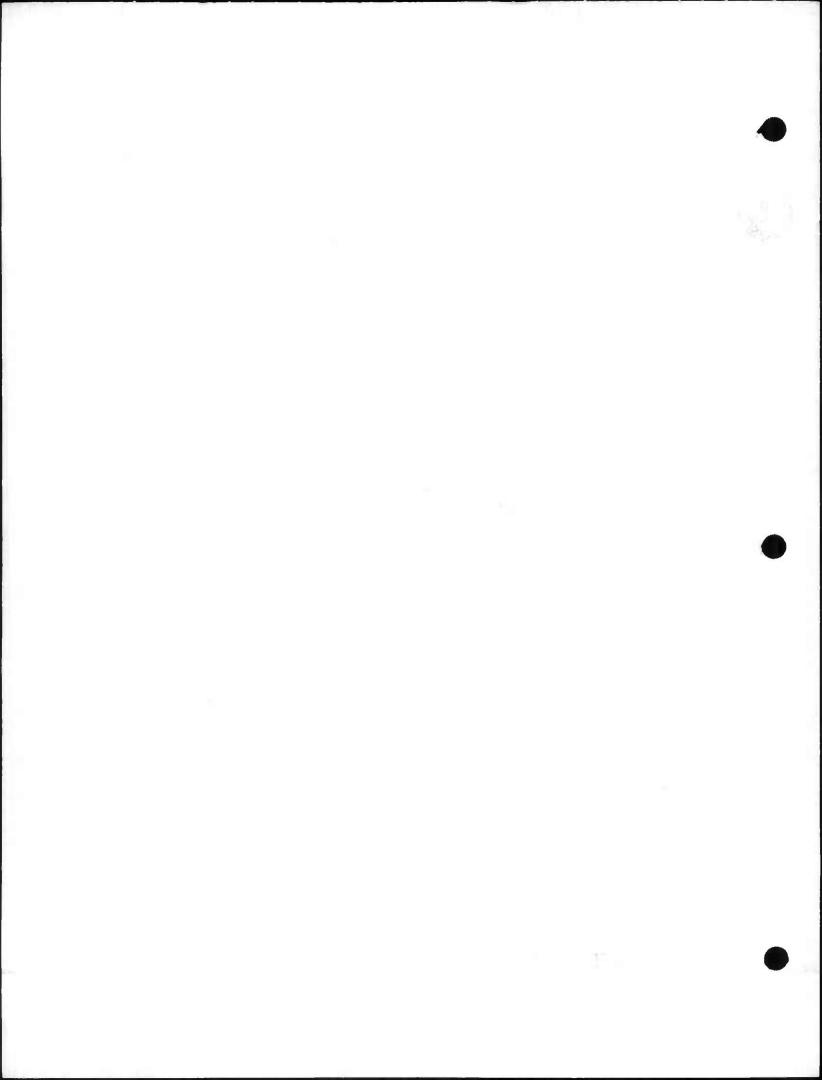
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	1 - FOR STATE REGISTRAR	STATE OF	MARYLAND A		RTMENT					HYGIEN REG. NO.	E		J 5 0 14 0
	1. DECEDENT'S NAME (First, Middle, Last) BENNIE						SMIT		2. DATE OF MONTH			YEAR	3. TIME OF DEATH 3:15 PM.
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. le.	st birthday) YRS,	IF UNDER			R 24 HRS.	7. DATE OF (Month, D	BIRTH lay, Year)	8. BIRTHPLACE Country)		LACE (State or Foreign
	9a. FACILITY NAME (If not institution, give street and number)					TOWN C	OR LOCATI	ION OF DE		1723	9c. COU	NTY OF DE	ATH
8	UNIT BLK. S.CA	LHOUN S	Т		BA	LT	IMOF	RE C	ITY			na	
	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNT	v		40. 007	Y, TOWN O								
DIRECTOR	MD	na			altim							- 1	IOd. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	-114			arczn	_	. ZIP COD	E			10g. CIT		I YES 2 NO
ER/	1314 West Lex	ington S	t										
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	Never Married 2 Married FORCES? 1 YES 2 NO If YES, GIVE WAR OR DATES 1.4. RACE — A Black, Wh. Specify Cuben, Mexican, Puerto Rican, atc.)  If YES, GIVE WAR OR DATES 1.4. RACE — A Black, Wh. Specify: Specify:							- American Indian, White, atc. Black				
	15. DECEDENT'S EDU		16a. DE	ECEDENT'S	USUAL OC	CUPATIO	ON .		16b. KI	ND OF BUS	INESS/INC		Black
COMPLETED	(Specify only highest grade	College (1-4 or 5		live kind of a. Do NOT u	work done d se retired.)	uring mo	st of worki	ng					
BE CON													
TO B													
	20a. METHOD OF DISPOSITION 1   Burlel 2   Cremation 3   Rem 4   Donation 5   Other (Specify)	oval from State	20b. PLACE cemetery, cre			TION (Na	me of		OATE	20c. LOC	CATION -	City or Town	n, Slate
_	21. SIGNATURE OF FUNERAL SERVICE LI	Ronal	ld Wade,	4-3-9	3 6	55w.	Balt		St eSt,B	alto,	MD 2		pard
	MANAGONATE CANCE (El-	List only one cer	use on eech line	ð.						or respir	ratory an	rest,	Approximata interval Between Onset and Death
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	C	TURED (OR AS A CONSE	OUENCE U	r):	A	NEL	IRY	SM				
ERTIF	that initiated events resulting in death) LAST	d	(OH AS A CONSE	QUENCE O	F): 								JA.
MEDICAL	PART II. Other significant condition	ns contributing to	desth but not i	resulting	in the und	derlying	cause	given in	,	PERFORI	MED?	a d	PERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  YES 2 NO
NA	25. WAS CASE REFERRED TO MEDICAL					26 Pt	ACE OF D	FATH /Ch	ack only one)				
S	EXAMINER?	HOSPITAL:	ER/Outpatient 3	DOA	OTHER 4 Number	:				#a II	NI T III	DIK	0.03111011
BY PHYSICIAN:	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	26a. OATE OF (Month, D	INJURY	26b. TIM		28c. INJI			28d. DESCRI				S.CALHOU ST
	3 Suicide 6 Could not be determined 4 Homicide Could not be determined determined								ite Number,				
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSI	ICIAN: To the best of	my knowledge, de	ath occum	ed at the lin	ne, date	and place	, and due	to the cause(	e) and mand	ner se stat	led. ne cause(e) s	and manner ea stated.
8 8	POL SIGNATURE AND TITLE OF CENTRIES	$\wedge$	FM				29c. LICE	C . M .	IBER		29d. DAT	E SIGNED (A	Aonth, Day, Year) - 1993
2	MARIO F GC	O COMPLETEO CAU	SE OF OEATH (ITE RMD 11	M 27) (Type	. Print) enn	Str	eet	, Ba	altim	ore,	Mai	rylaı	nd 21201

which Davidon Rentedle



188-03-6815 A 1 X M 2 F 8.5 burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number DIRECTOR 5446 MASEFIELD RD RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY MD. BALTIMORE FUNERAL 10e. STREET AND NUMBER 5446 MASEFIELD RD 24 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married
3 Widowed 4 Divorced FORCES? 1 YES 2- NO IF YES, GIVE WAR OR DATES BY detached for use as the COMPLETED 15. DECEDENT'S EOUCATION (Specify only high Elementary/Secondary (0-12) College (1-4 or 5 +) 8th once. 17. FATHER'S NAME (First, Middle, Last) page 5 should be EDWARD SHADELL notified at BE 19a, INFORMANT'S NAME (Type/Print) 2 WINIFRED SHADELL e 20s. METHOD OF DISPOSITION must funeral director, HORELAND. medicai examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSE Hulle M005S the removal ysician and completely filled in by prior to burlal, cremation, or remo shock, or heert failure. List only one cause on each line. IMMEDIATE CAUSE (Final the disease or condition Olration OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within resulting in death) traumatic event, DIVISION OF VITAL RECORDS, P.O. BOX 68760, DUE TO (OR AS A CONSEQUENCE OF): , infarct MEDICAL CERTIFICATION Sequantially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): the attending physician I Mental Hyglene prior tr cause. Enter UNDERLYING CAUSE (Disease or Injury injury, or other OUE TO (OR AS A CONSEQUENCE OF): thet initiated eventa resulting in death) LAST has been signed by the Dept. of Health and shows any PHYSICIAN: 23 25. WAS CASE REFERRED TO-MEDICAL this certificate h EXAMINER? HOSPITAL 1 Inpetient 2 ER/Outpatient 3 DOA 10 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) marked, 1 Natural 5 Pending BY After 1 2 Accident 3 Suicide ERAL OIRECTOR: A in 72 hours after d If Item 28 is COMPLETED 29a, CERTIFIER PITAL 296. SIGNATURE AND TITLE OF CERTIFIER ATTENDING BE 2

1993

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO. 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First Middle Last) 3. TIME OF DEATH YEAR HAROLD EDWARD SHADELI 4-5-93 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR DATE OF BIRTH IF UNDER 24 HRS. B. BIRTHPLACE (State or Foreign (Morth, Day, Year) 10-21-1907 PENNSYLVANIA 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH BALTIMORE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 TYES 2 NO 10f ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 21229 U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 YES 2 ME NO Specify WHITE 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INOUSTRY PRODUCE SUPERVISOR **GROCERY** 18. MOTHER'S NAME (First, Middle, Maiden Surname) HATTIE DETURK 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5446 MASEFIELD RD., BALTIMORE, MD. 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State MEMORIAL CEMETERY 4-8 BALTO. MD 22. NAME AND ADDRESS OF FACILITY STERLING ASHTON FUNERAL HOME, 736 EDMONDSON AVE. CATONSVILLE 23. PART I. Entar the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cardiec or respiratory arrest, Approximate Interval Between **Onset and Death** clements a PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE PERFORMED? 5/adder CA 1 YES 2 NO OF DEATH? 1 TES 2 NO 26. PLACE OF DEATH (Check only one) OTHER: 4 Nursing Home 5 N. Residence 8 Other (Specify) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29d. DATE SIGNED (Month, Day, Year) 3063 PHYSICIAN 6 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH 411 OLD 8151N65R HEED STACK 95515

• 8 B

## BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

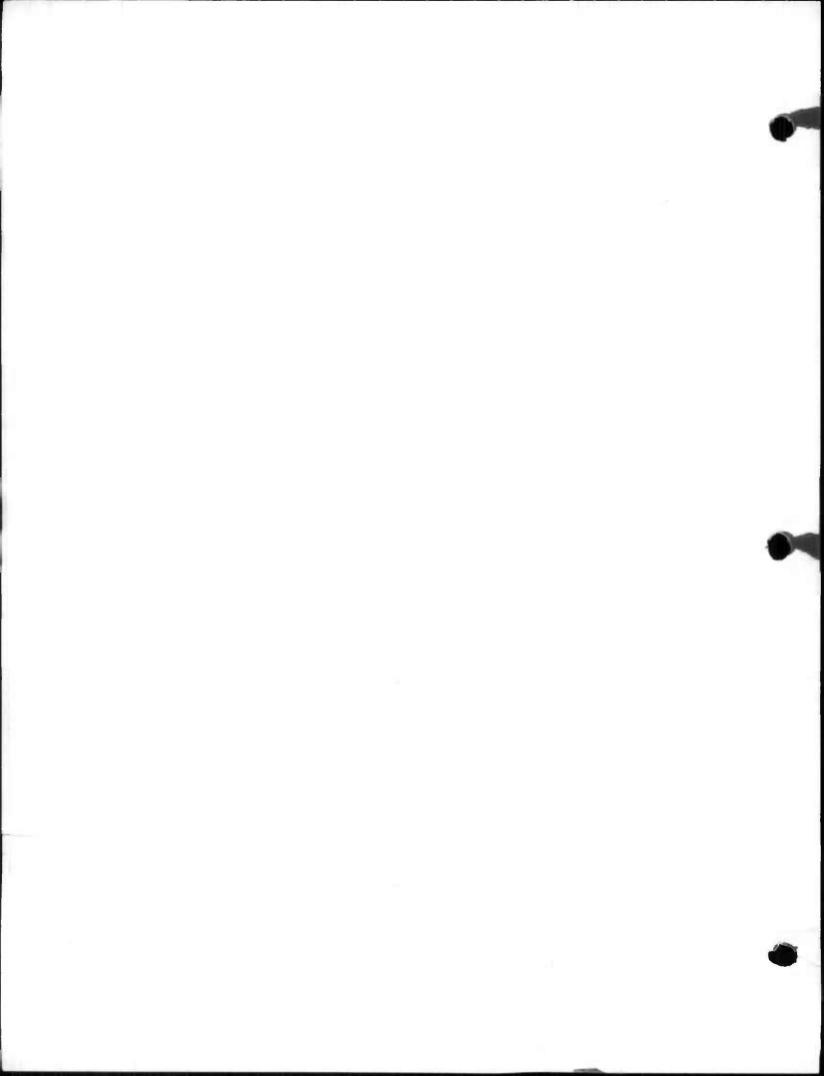
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within security death. Page 8 may be retained by the hospital or attending physician.

TO THE FUNERAL OHECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

REGISTRAR		CERTIFIC	AILU	F DEATH	1	REG. NO			
CHARLES WILMER SANTMYER  2. DATE OF DEATH MONTH DAY YEAR 4 6 93 0920									
4. SOCIAL SECURITY NUMBER 5. SEX 212-05-6116 1XXM	8. AGE (In yrs	//	UNDER 1 YEAR		HRS. 7.	DATE OF BIRTH (Month, Day, Year) 4/25/09		Country)	CE (State or Foreign
9a. FACILITY NAME (If not institution, give street and n	umber)	9	9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEAT						
St. Agnes Hospital			Baltimore						
10a. STATE 10b. COUNTY		10c. CITY, T	OWN OR LO					100	d. INSIDE CITY
MARYLAND				BALTIMO	RE				X YES 2 NO
171 CORRIGE CORREGE				101. ZIP CODE 212	20			ZEN OF WHA	T COUNTRY?
1716 SPENCE STREET  11. MARITAL STATUS  12. WAS	DECEDENT EVER IN U.S	S. ARMED	13. WAS 0			ORIGIN? (Specify Yes		14. RACE -	American Indian,
1 Never Married 2 Married FOR IF Y	NO	If yes, specify Cuban, Maxican, Puerto Rican, atc.)  1 YES 2 NO Specify:					Black, W Specify:	WHITE	
15. OECEDENT'S EDUCATION (Specify only highest grade completed	0 164	Give kind of work	done during	TION most of working		16b. KIND OF BU	SINESS/IND	USTRY	
Elementary/Secondary (0-12) College 8TH GRADE	(1-4 or 5+)	WATCH E		ER		GAS C	OMPAN	ΙΥ	
17. FATHER'S NAME (First, Middle, Lest)		WIII OII L	HOLINE		R'S NAME (	(First, Middle, Maiden			
JOHN SANTMYER				M/	MIE	SHANKS			
tea, INFORMANT'S NAME (Type/Print)						e Number, City or Tow			1007
MARY BARBEHENN 200. METHOD OF DISPOSITION	20b. P1	ACE OF DISPOSITI				- ELKRI		MD . Z	
1 🖓 Burial 2 🗌 Cremation 3 🗆 Ramoval from 4 🗓 Donation 5 🗆 Other (Specify)	er place)						TIMORE		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC.									
23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate									
ahock, or heart failure. List onig		ilna.	enter the	mode of dyni	y, such ac	a cardiac of resp	natory arr	·····	interval Between Onset and Death
resulting in deeth)	DUE TO (OR AS A CO								
II b	ng Cancer								4 mons.
Sequentially liet conditione, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CO	NSEQUENCE OF):							
CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CO	NSEQUENCE OF):	ENCE OF):						
resulting in deeth) LAST									
PART ii. Other eignificant conditions contri	buting to death but a	not resulting in	the underly	/ing cause gi	ven in Par	rt I. 24a. WAS AN			ERE AUTOPSY FINDINGS
						_ 1 TYES		co	OMPLETION OF CAUSE
						-		1 (	YES 2 NO
25. WAS CASE REFERRED TO MEDICAL			26	. PLACE OF DE	ATH (Check	only one)			
EXAMINER? Y  1 YES 2 NO  1 Injury	PITAL: estient 2 ER/Outpatie		THER:	iome 5 🗆 Resi	Idence 6	Other (Specify)			
1 🖾 Natural 5 🗌 Pending	a. DATE OF INJURY (Month, Dey, Year)	26b. TIME (	TY	INJURY AT WORK?  YES 2		Id. DESCRIBE HOW	INJURY OC	CURED	
Accident	e. PLACE OF INJURY — building, atc. (Spec/ly)	At home, farm, stre	et, factory, c	ffice	26	Bt. LOCATION (Street City or Town, State		r or Rural Rout	e Number,
298. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To									nd manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER	A				ISE NUMBE				onth, Day, Year)
Ann E. Reed, M.D.	XX	۳	_	D <del>4</del> 1	843		<b>•</b>	7/0/93	4/6/93
30. NAME AND ADDRESS OF PERSON WHO COMPL St. Agnes Hospital	900 Caton	Avenue		MD					
APR 0 7 1993	REGISTRAN S SIGNATU	Handelle.							



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending invariant.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the manner of the page 1.2 served
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If them 28 is marked, or them 23 shows any Intervior or other traumatic event the medical examines must be notified at once

MEDICAL

BY

COMPLETED

BE

2

2. DATE OF DEATH MONTH 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 2 4- 3 DAY 9 3 Mary Virginia Stevens 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF IMPER 24 MIRS 8. BIRTHPLACE (State or 1 M 2 SF HOURS 216-32-7673 A 82 YRS. 9/16/10 Maryland 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Balto. Co. General Hospital Randallstown Baltimore RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Baltimore 1 YES 2 XNO 10a. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3707 Croydon Road 21207 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
It yes, specify Cuban, Mexican, Puarto Rican, etc.)
1 YES 2 XNO Specify: 14. RACE — American Indian, 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 th grade Housewife 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Walter C. Slemaker Mary Rose Slemaker BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr. George B. Stevens 3707 Croydon Road Baltimore, MD 21207 20a. METHOD OF DISPOSITION
1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — Cify or Town, State OATE Parkwood Cemetery 4 Donation 5 Other (Specify) Parkville, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, INC. amor 8728 Liberty Road Randallstown, MD 21133 23. PART I Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fellure. List only one ceuse on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death CHAMONIE OBSTANCTIVE LING DISTANCE disease or condition resulting in death) END-STABE DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? Fachas-HURAT 1 YES 2 NO Valuelan 1 TES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER:
4 | Nursing Home 5 | Residence 8 | Other (Specify) 1 | Inpetient 2 | ER/Outpetient 3 | DOA 26a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCUREO 1 Netural 5 Pending Investigation 1 YES 2 NO 2 Accident 28s. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide # Could not be 4 Homicide 29a. CERTIFIER

(Chart only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Me aD. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BCG4 RANDALISTONN MD 2433 ONUANDO BI CONTURN MED 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Mindson

OHMH-18 Rev 1/89

A.

1	-	STATE REGISTRAI
г	_	

	1 - STATE REGISTRAR		ICATE OF			EG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF			3. TIME OF DEATH		
		ollins Ste	рр		MONTH	DAY	Q Z	3:05 PM		
	4. SOCIAL SECURITY NUMBER 5. SEX	AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HR	MA		0. BIRTH	IPLACE (State or Foreign		
	237-07-6286 1□ M 2 🖫 🗲	82 YRS.	MONTHS DAYS	HOURS MIN	(Month, De 12-5-		N	m Carolina		
	Se. FACILITY NAME (If not institution, give street end number)		9b. CITY, TOWN	OR LOCATION OF			OUNTY OF D			
OR	Frederick Memorial Hospita	1	Frede	rick		Er	radari	ck County		
כ	RESIDENCE OF DECEDENT  10e, STATE  10b, COUNTY					1 1	edell			
IRE			Y, TOWN OR LOCA	TION				10d. INSIDE CITY LIMITS?		
L D	Maryland Carroll County		t. Airy					1 YES 2 K NO		
RA			10	f. ZIP CODE		10g. (		WHAT COUNTRY?		
FUNERAL DIRECTOR	2802 Gillis Rd.	EVER IN U.S. ARMED	1 40 1110 000	2177			USA			
F	1 Never Married 2 Married FORCES? 1	YES 2 K NO	If yes, sp	ecify Cuban, Ms	PANIC ORIGIN? (S xicen, Puerto Ricer	pecify Yes or No- 1, atc.)		E — Americen Indian, k, White, etc.		
BY	\$₹∑ Widowed 4 □ Divorced IF YES, GIVE WAI	R OR DATES	1 🗍 YES	2 NO Sp	ecity:		Spec	White		
ED	15. DECEDENT'S EDUCATION		USUAL OCCUPATION		16b, KIN	D OF BUSINESS/	INDUSTRY	WILLE		
Ë	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5 +)	(Give kind of life. Do NOT u	work done during mo se retired.)	ost of working						
P.	11th Grade	Supervi	sor		Te	xtile M	1111			
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)			18. MOTHER'S	NAME (First, Middle					
BE (	William P. Gilliam			Anni	e Oates					
TO B	19e. INFORMANT'S NAME (Type/Print)	19b. MAILING	ADORESS (Street				Zip Code)			
ř	Mrs. Geraldine E. Collins	Eggue 2802	Gillis F	Rd. Mt	. Airv.	MD 21	771			
	20a. METHOD OF DISPOSITION  ty⊠gurial 2 □ Cremation 3 □ Removal from State	20b. PLACE AND DATE	OF DISPOSITION (NO		DATE	20c. LOCATION	— City or To	wn, Stats		
	4 Donation 5 Other (Specify)	Mt. Moriah	<u>Baptist</u>	Church	h 4⊢8 <b>-</b> 93	Edneyv	ille,	NC		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME A	ND ADDRESS OF	FACILITY n Funera					
	boly K Analish							, MD 21784		
	23. PART Enter the diseeses, Dr complications that	caused the deeth. Dp	not enter the mo	de of dying, s	uch es cardiec	Dr reepiratory	arreet.	Approximete		
	ehock, or heert fellure. List only one ceuse IMMEDIATE CAUSE (Final	o Dn each line.						interval Between Onset and Death		
	disease or condition a. Cardiac Arrest									
		R AS A CONSEQUENCE O	F):					· · ·		
z	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):									
5	ir any, leading to immediate	R AS A CONSEQUENCE 9	r):			/	_	1		
2	CAUSE. Enter UNDERLYING CAUSE (Disease or injury	ute ant	Prior.	MYO	cardi	2/10	tara	un week		
E	that initiated events resulting in deeth) LAST	R AS A CONSEQUENCE O	F):							
CERTIFICATION	d									
	PART II. Other aignificant conditions contributing to d	eath but not resulting	in the underlyin	g cause given	in Part i. 24e	. WAS AN AUTOPS	Y 24b	WERE AUTOPSY FINOINGS		
DICAL	Dighetes Ny	perten	21000		1.5	PERFORMEO?	-	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
MEC						J 123 243-110		OF DEATH?		
								1 YES 2 NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		28. PI	ACE OF DEATH	(Check only one)					
Sic	EXAMINER?  1 YES 2 ING Inpatient 2   E	R/Outpatient 3 DOA	OTHER:	e 5 🗆 Besiden	ce 6 🗆 Other (Sp	eciha				
Ě	27. MANNER OF DEATH 200. DATE OF IN	IJURY 28b. TIM	E OF 28c. INJ	URY AT		BE HOW INJURY	OCCURED			
BYF	1 Netural 5 Pending (Month, Day, 2 Accident Investigation	mar)		YES 2 NO						
		INJURY — At home, ferm,	street, factory, offic	•	28f. LOCATIO	N (Street and Num	ber or Rural F	Poute Number,		
E	4 Homicide determined	a. (Specify)			City or lo	wn, Stete)				
COMPLETED	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of m	y knowledge, death occurr	ed at the time, date	end place, end	due to the cause/s	and mauner ea i	eteted			
MC	one) 2 MEDICAL EXAMINER: On the besis of exam							and menner as stated.		
	29b. SIGNATURE AND 2017 E OF CERTIFIER	1		29c. LICENSE				(Month, Dily, Year)		
BE	(16. C) /	Month	t mo	> 3	5/63	290.0	4	< 16 ?		
2	30. NAME AND MODRESS OF PERSON WHO COMPLETED CAUSE	OF OEATH (ITEM 27) (Type	Print)	10	٠ / ٥ / ٠		-//	2/13		
	Ali Ti AFrank	tel 30	10 W	9th	5+ 4	rede	111	4 MD		
2	31. DATE FILED (Month, Day, Year) 32. REGISTRAR					Tuc	10	- /		
	the second secon									

BALTIMORE, MARYLAND 212 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or an TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use to be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.

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DHMH-18 Rev 1/89

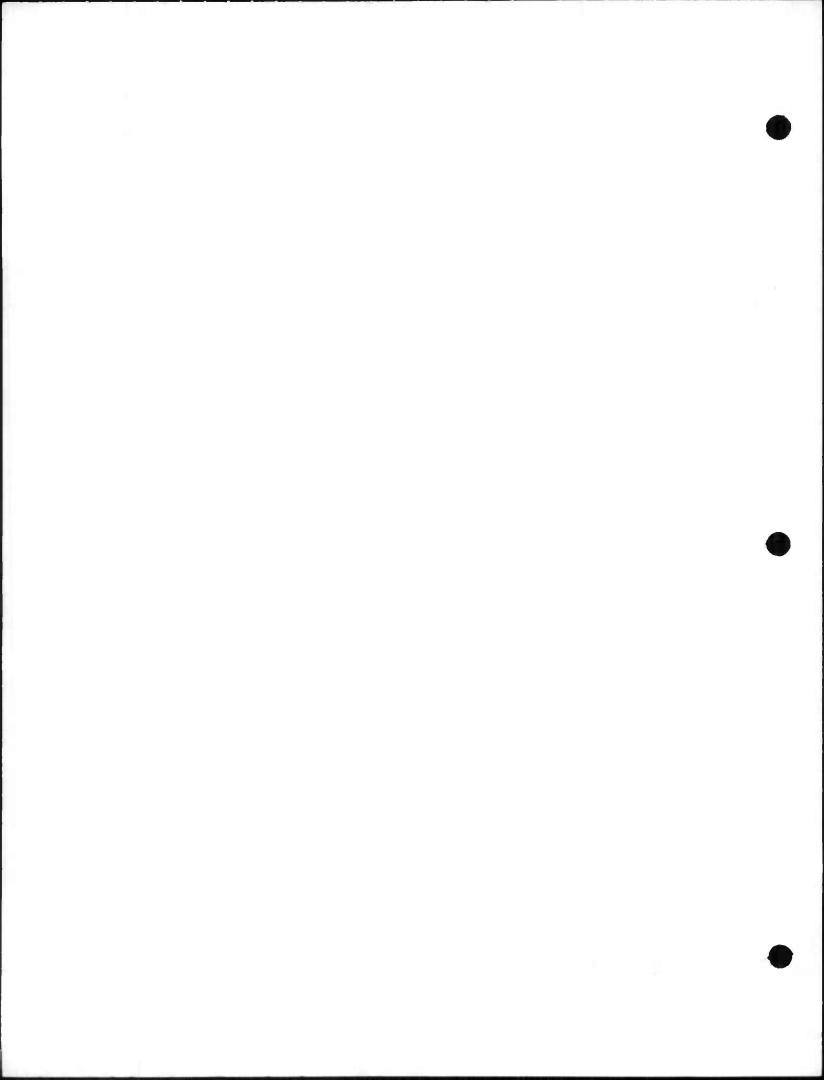
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BALTIMORE, MARYLAND 21215-9020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	1 - STATE REGISTRAR	STATE OF MARYLAN	ND / DEPART	MENT OF H	IEALTH AND DEATH	MENTAL HYG				
	1. DECEDENT'S NAME (First, Middle, Last)  MARY STRICE	KLAND SMITH				2. DATE OF DEA	TH	YEAR 3. TIME OF DEATH 4 P.M. M		
	216-34-4728	1 M 2 F 61	YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTY (Month, Day, Ye 2/16/]	er)	ORTH CAROLINA		
TOR	3948 OAKFORD AVE			BALTIM	ORE	EATH	9c. COUNT	Y OF DEATH		
DIRECTOR	10a. STATE 10b. COUNTY MARYLAND			TIMORE	TION		10d. INSIDE CITY LIMITS? 1 TYES 2 NO			
JERAL	3948 OAKFORD AV	Е.		101	21215		USA	10g. CITIZEN OF WNAT COUNTRY? USA		
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 AMerried 3 Widowed 4 Divorced	12. WAS DECEOENT EVER IN U FORCES? 1 _ YES IF YES, GIVE WAR OR DATE	2 NO		ecity Cuban, Maxico	NIC ORIGIN? (Speci an, Puarto Rican, at- y:				
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)	ompleted) College (1-4 or 5+)	ISUAL OCCUPATION done during mo retired.)	st of working	F BUSINESS/INDUS					
12 4 ROSEWOOD STATE HOSPITAL TEACHER  17. FATHER'S NAME (First, Middle, Lest)  EARL STRICKLAND  FRMA STRICKLAND										
TO BE	19s. INFORMANT'S NAME (Type/Print)	LIAND			nd Number or Rural	STRICKLA Route Number, City of	or Town, State, Zip Co			
	HEINER SMITH  3948 OAKFORD AVE, BALTIMORE, MARYLAND 2121  200. METHOD OF DISPOSITION  200. PLACE AND DATE OF DISPOSITION (Name of the control									
1 XBuriel 2 Cremetton 3 Removal from State 4 Donatton 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  22. NAME AND ADDRESS OF FACILITY										
	Theyd	Med	7	ESTEP 1300	BROTHER EUTAW PI	RS FUNERA	TIMORE	MD 21217		
	23. PART I. Enter the diseases, or co shock, of heart fellure. Li IMMEDIATE CAUSE (Final	only one cause on each	h iina.				eapiratory arrea	Approximata Interval Between Onset and Death		
	disease or condition resulting in death)	PUE TO OR AS A C	DITE OF	/ fail.	re			3 yays		
ATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING  Discretized to the sequence of:  Discretized to the sequence of:  Sequentially list conditions, our to lor as a consequence of:  Discretized to the sequence of:  Sequentially list conditions, our to lor as a consequence of:  Discretized to the sequence of:  Sequentially list conditions, our to lor as a consequence of:									
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CO	ONSEQUENCE OF):							
MEDICAL C	PART II. Other aignificant conditions	contributing to death but	not reculting in	tha underlying	cause given in	PE	IS AN AUTOPSY REFORMED?	24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE		
IN: ME						_		OF DEATH? 1 □ YES 2 □ NO		
PHYSICIAN:		HOSPITAL:		OTHER:	ACE OF DEATH (Ch	8 Other (Specify				
	27. MANNER OF DEATH  1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME INJUI	OF 28c, INJ	URY AT RK?		OW INJURY OCCUP	RED		
2 Accident investigation 28s PLACE OF INHERY. At home farm street feeting office.							Rural Route Number,			
COMPLETED		AN: To the best of my knowledge. On the basis of examination ar								
H	29b. SIGNATURE AND TITLE OF CERTIFIER	Its for			D380	ABER	29d. DATE S	IGNED (Month, Day, Year) 4/2/33		
5	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH	Hopkins	Hospi	HI. 600	N. Wal	Fest. E	Balkina Mo		
10	31. DATE FILEO (Month, losy, Year)  APR = 7 1993	32. REGISTRAR'S SIGNATU	Brolate		,		_			



BALTIMORE, MARYLAND 21215-0020

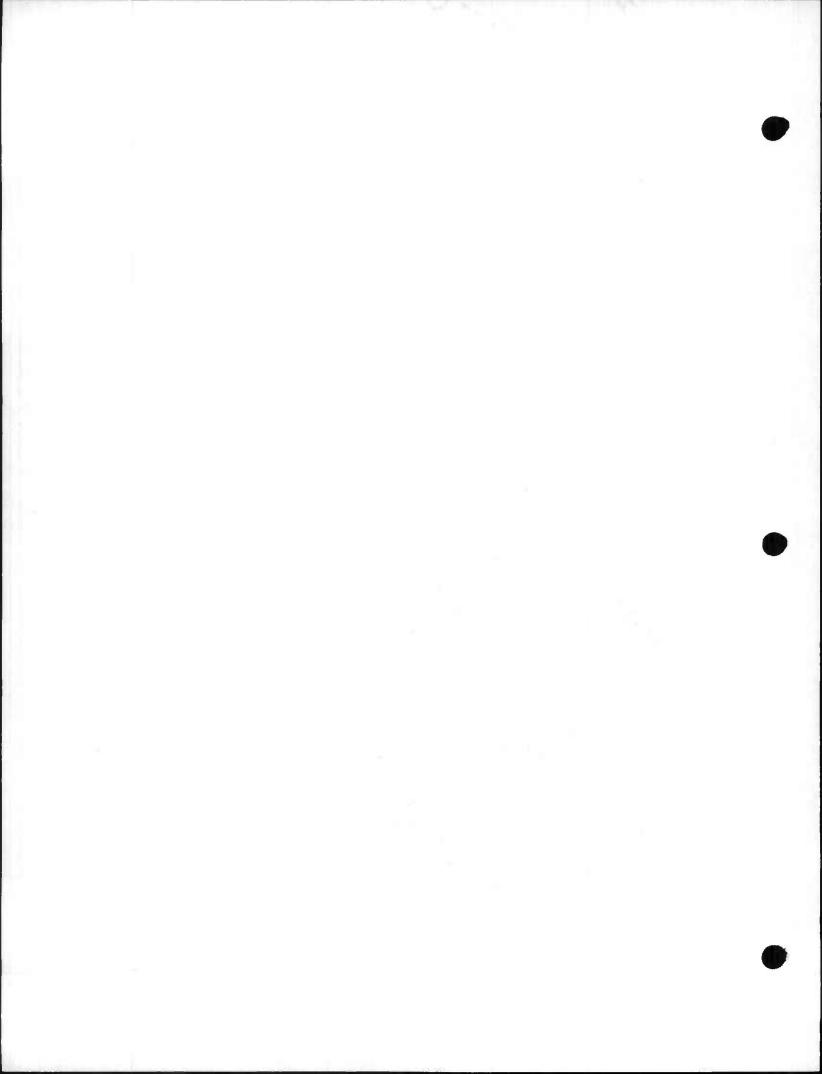
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI	MENT OF HEALTH AN	D MENTAL HYGIENE REG. NO.	55 05032				
- 3	1. DECEDENT'S NAME (First, Middle, Les	()			2. DATE OF DEATH MONTH DAY	3. TIME OF DEATH				
		EVA SLAD			04 01	93 11.000				
9	4. SOCIAL SECURITY NUMBER 213-12-657			FUNDER 1 YEAR IF UNDER 24 HR INTHS DAYS HOURS MIN	MANAGE CALL MINE	North Carolina				
1	9a. FACILITY NAME (If not institution, giv	street and number)	9	b. CITY, TOWN OR LOCATION OF	F DEATH	9c. COUNTY OF DEATH				
TOR	PRINCE GEORGE'S	HOSPITAL CEN	TER	CHEVERLY		PRINCE GEORGE				
DIRECTOR	DC 10a. STATE 10b. COUR	пү		own or Location Ington		10d. INSIDE CITY LIMITS? 1 → YES 2 → NO				
FUNERAL	10o. STREET AND NUMBER 2933 Carlto	n Avenue		101. ZIP CODE 20018		10g. CITIZEN OF WHAT COUNTRY? USA				
BY FUNE	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES	2 NO	If yes, specify Cuban, Me	SPANIC ORIGIN? (Specify Yes o xican, Puerto Rican, etc.) secify:	or No- 14. RACE — American Indian, Black, White, etc. Specify:Black				
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  18b. KIND OF BUSINESS/INDUSTRY									
P	0 . 0 . 1	None	Housewi	Ee						
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AL	DRESS (Street and Number or Ru	ural Route Number, City or Town	State Zin Code)				
10	Geo	rge R Slade	Same	as 10a,b,c,d	,e,&f					
	1 XBuriel 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State	National	Mem Park	4/6/93 Lau	ATION — City or Town, State urel, Md.				
6	21. SIGNATURE OF FUNERAL SERVICE	Smilas	,	22. NAME AND ADDRESS OF	FACILITY John T RI 3030 12th St	hines Co., Inc. NE, DC 20017				
CERTIFICATION	ahock, or heart feliure. List only ona ceuse on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):  The provided in the condition of the condition of the course. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):									
MEDICAL	PART II. Other significent conditi	ons contributing to deeth b	out not resulting in	he underlying cause given	1 in Part I. 24a. WAS AN A PERFORM 1 ☐ YES 2 §	MED? AVAILABLE PRIOR TO				
AN	25. WAS CASE REFERRED TO MEDICAL			26. PLACE OF DEATH	(Check only one)					
Sic	EXAMINER?  1 YES 2 NO	HOSPITAL: 1- Inpatient 2 ER/Out	setlent 3 DOA 4	THER:						
PHYSICIAN:	27. MANNER OF DEATH  1 Netural 5 Pending	26e. DATE OF INJURY (Month, Day, Year)	28b. TIME C	F 28c. INJURY AT	28d. DESCRIBE HOW IN.	JURY OCCURED				
ED BY	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJUST	— At home, lerm, stre							
COMPLETED		/SICIAN: To the best of my know NER: On the basis of axaminatio				er as stated. due to the cause(s) and manner as stated.				
TO BE C	296. SIGNATURE AND THE OF CERTIF	Mund		29c. LICENSE 275		29d. DATE SIGNED (Month, Day, Year)  4/3/93				
F	30. NAME AND ADDRESS OF PERSON Y	VHO COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Pri	nt)		· ·				
	APR 6 1993	32. REGISTRAR'S SIGN	ATURE							

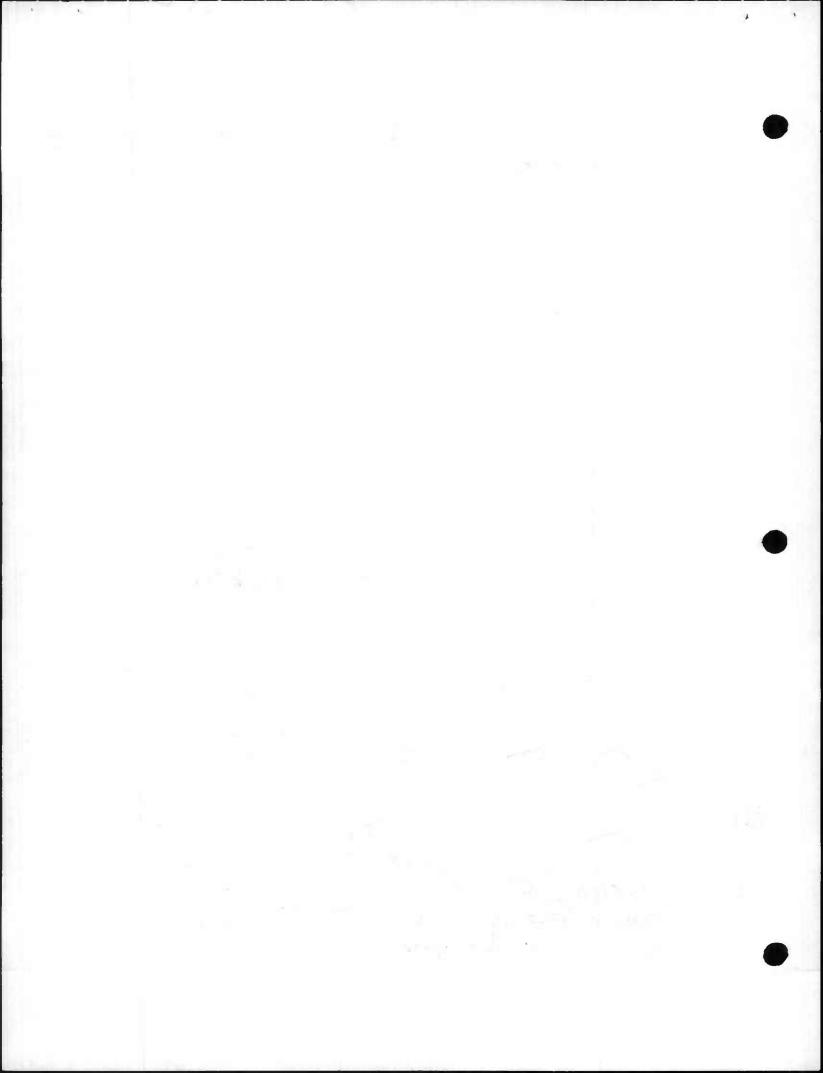


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	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEP/ CERTI	RTMEN	T OF H	EALTH DEAT	AND ME	NTAL HYGIEI		J	09833
1	1. DECEDENT'S NAME (First, Middle, Last) ESHIPER, SCHU	xartz					2.	DATE OF DEATH		YEAR	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 213-13-2001	1 □ M 2 🔯 F	(In yrs. lest birthde	MONTHS	DAYS	IF UNDER	24 HRS. 7. MIN. 3	DATE OF BIRTH (Mogth, Day Year)		-	ACE (State or Foreign
TOR	90. FACILITY NAME (If not institution, give s Suburban Hospi  RESIDENCE OF DECEDENT				thes		ON OF DEATH		9c. COUNT Mon	tgon	
DIRECTOR	10e. STATE 10b. COUNT	tgomery		ROCK							Dd. INSIDE CITY LIMITS?  YES 2 ND
FUNERAL	100. STREET AND NUMBER 6121 Montrose I				101	208		10g. CITIZEN OF			AT COUNTRY?
8≺	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	FORCES? 1 YES 2/1/10 If yes, specify Cuben,				OF HISPANIC ORIGIN? (Specify Yes or No.— 14. R/ sn, Mexican, Puerto Rican, etc.)				American Indian, White, etc.
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  12    College (1-4 or 5+)   Condept (1-4 or 5+)   College (1								STRY		
BE CON	17. FATHER'S NAME (First, Middle, Last) Jacob Amiel					For	tune	First Middle, Melder e Brakl	na		
	Joseph Ebbo		626	7 64	th A	venu		Number, City or To Riverda	le, M	d. 2	20737
	A Burist 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from Stats	netery crembiogy	Tahanplac	dem.	Gar	den	93 Fa		Chur	ch, Va.
1	21. SIGNATURE OF FUNERAL SERVICE LIN	M C (	ain	I <sup>2</sup> v	rame and rest	Pear Chu	s of facility SON arch,	Funeral Va. 22	L Home 2046	es	
	IMMEDIATE CAUSE (Final	complications that cause List Dnly one cause on e	ach lina.							et,	Approximata Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	с	A CONSEQUENCE		¥.						
MEDICAL C	PART II. Other algorificant condition	Lascula A	out not resulting	g in the u	nderiying	Cause g	iven in Par	1  YES	RMED?	CO OF	THE AUTOPSY FINDINGS. ALLABLE PRIOR TO OMPLETION OF CAUSE OBSTATT  YES 2   NO
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PL	ACE OF DE	ATH /Check o	(rily one)			
PHYSIC	1 VES 2 ND	HOSPITAL: 1 Inpetient 2 I ER/Outs 28s. DATE OF INJURY (Month, Day, War)	28b. T	IME OF	28c. INJ	TA YEL		Other (Specify)	INJURY OCCU	RED	
ED BY	1 Netural 5 Pending 2 Accident Investigation 3 Suicide S Could not be determined	28e. PLACE OF INJURY building, str. (Spec	- At home, farm	M street, fac	t 🗆 Y	PES 2	_	LOCATION (Street City or Town, State	and Number or	Rurel Rout	e Number,
COMPLET		CIAN: To the best of my know									nd metiger as stated
O BE CO	29b. SIGNATURE-AND TITLE OF CERTIFIE	me				29c, LICEI	NSE NUMBER	1	29d, DATE S	IGNED (M	noth Day Year)
-	30. NAME AND ADDRESS OF PERSON WH	han Mus	Le-	pe, Print)	2/	Me	ntre	e Re	e 12	cele	3 v,16 m

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		1 - STATE REGISTRAR		0		CE				DEATH	MENTAL	REG. N	О.		
		1. DECEDENT'S NAME (First, Mid	idle, Last)	0.0.1		44.0					2. DATE O	F DEATH	DAY	_YEAR	3. TIME OF DEATH
		J AM	150			1101					4	- 1	2	93	43
77		4. SOCIAL SECURITY NUMBER	132	5. SEX	6. AGE	(In yrs. last	pirthday)	IF UNDER	1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.		BIRTH   Day, Year)     19	16	Country Teni	y)
3 should	- 1	Se. FACILITY NAME (If not institut	tion, give at	reet and number)				9b. CITY,	TOWN (	OR LOCATION OF		/		UNTY OF D	EATH
1, 2, 3	DIRECTOR	Mercy Medi	cal	Center				Ва	alt	o.City	Md.				
	35		. COUNTY	,			10c. CITY	, TOWN O	R LOCA	TION					10d. INSIDE CITY
.#. 		Maryland					Ba	1to	.Ci	ty,Md.					tXXYES 2 □ NO
Ti berti	FUNERAL	10e. STREET AND NUMBER							10	. ZIP CODE			10g. CI	TIZEN OF W	HAT COUNTRY?
an. transit	NE I	1627 Race S	St.						$\perp$	21230				USA	
1215-0020 or attending physician. r use as the burial-transit permit. Pages	BY FU	11. MARITAL STATUS  1 Never Married 2 Mar  3 Widowed 4 Divorced	ried	12. WAS DECEOEN FORCES? 1 IF YES, GIVE N	YES	2 VN	WED O		f yes, sp	ENDENT OF HISP/ ecify Cuban, Mexic 2 NO Spec	an, Puerto Ri		fes or No-	14. RACE Black Specif	— American Indian, , White, etc.
15- tendin		15. DECEOE		CATION		16a DEC	CEDENT'S	IISUAL O	CHRATI	200	105.0	CHID OF B	USINESS/IN	IDLIGTON	White
2121 al or atte for use a	13	(Specify only hig Elementary/Secondary (0-12)	hest grade	completed) College (1-4 or 5	4)	(Gh	ne kind of w Do NOT us	rork done o	during mo	est of working	100.	CIND OF B	OSINE33/III	eDOSTRY	
	P	8th.Grade				Ass	semb	1y 1	Lin	е	G	ener	cal N	lotor	S
AND the hospital detached to	COMPLETED	17. FATHER'S NAME (First, Middle	, Last)							18. MOTHER'S N					
\$ \$ € ₹	BE (	James		J.	Sa	mmor	ıs			Jı	ılia	_		F	Pavne
MARY retained by 5 should be notified at	10	19a. INFORMANT'S NAME (Type/I	Print)			19b	MAILING	ADDRESS	(Street a	and Number or Rura	l Route Numbe	r, City or Ti	own, State, 2		
		Mrs.Helen	LS	ammons			162	7 R	ace	St. Ba	_	_			
FORE, I e 6 may be r ector, page 5 must be n		20e. METHOD OF DISPOSITION  1 Burlel 2 Cremation 3  4 Donation 8 Other (Spe	3 🗆 Remo	oval from State	20b cen	netery, cren	ND OATE C	FDISPOS her place)	ITION (No	ame of	OATE	20c. l	LOCATION -	- City or To	vn, State
NAC direc		21. SIGNATURE OF UNERAL SE				LOU	laon	Pai	CK	Cemetei	Y4/6	Bal	Lto.	city,	Ma.
BALTIMORE, irs after death. Page 6 may be no by the funeral director, page removal.		///	- 1	0,	1/	1		1	NOWL A	TO ADDRESS OF F		alto	.Md	. 212	230
BA fter de the f loval.		an	1	<u>U - 1</u>	104	415	>	Mo	cCu	11y Fur	neral	Hor	ne,13	30 E.	Fort Ave
hours after ed in by the or remova		23. PART I. Enter the disee shock, or heart	failure.	List only one car	use on e	d the dea	nth. Do n	ot enter	the mo	de of dying, su	ch as cardi	ec or res	piratory a	rrest,	Approximata interval Between
24 Fills		iMMEDIATE CAUSE (Fine) disease or condition			R	)	2	Sta.		Aug	.4				Onset and Deati
o, withir		resulting in death)		DUE TO	(OR AS A	S ZV	UENCE OF	40-	14	Tues					
X 68760, executed within and completely to burlal, crematimatic event,	7				N	100	Total	of.	C.	Belo D	uct	Con	Cino	144	j
OX 68 e be execute sician and c rior to buris	CERTIFICATION	Sequentially list conditions if any, leading to immediate		DUE TO	(OR AS A	CONSEQ	UENCE OF	):	_		ucr		CVNG	114	1
BO) ate be nysician prior	CA	cause. Enter UNDERLYING CAUSE (Disease or injury	1	h											
P.O. B h certificat anding phy Hygiene p or other	H	that initiated events resulting in death) LAST		DUE TO	(OR AS A	CONSEQ	UENCE OF	):							
	ER	reading in death) LAST		1											
DS the d		PART II. Other significent	ondition	s contributing to	death b	out not re	suiting i	n the un	derlyin	g cause given in	n Part I.		N AUTOPSY	24b.	WERE AUTOPSY FINDINGS
ORC s that the ned by ith and any in	DICAL	Sex	70	mice									ORMED?		MAILABLE PRIOR TO COMPLETION OF CAUSE
	ME	0									21			3,000	OF DEATH?
- > 0 -i															
一年 報報 看	CIAN:	25. WAS CASE REFERRED TO ME EXAMINER?	EDICAL	HOSPITAL:				OTHER		ACE OF OEATH (C	heck only one				
OF VI PHYSICIAN: this certifical with the St rked, or It	HYSI	1 TYES 2 NO		Impatient 2		patient 3		4 🗌 Nuri	ing Hom	e 5 🗆 Residence	6 🗆 Other	(Specify)			
OF PHYSIC this ce with th	표	27. MANNER OF OEATH  Hatural 5 Period	lina	26a. DATE Of (Month, L	INJURY Day, Year)		26b. TIME INJ	URY	WC	URY AT	28d. DESC	RIBE HOW	O YRULNI V	CCURED	
a in the C	B	2 Accident Inves	stigation	28e. PLACE C	E IN ILION	/ At how	no form o			YES 2 NO		Page 1 co.		- 1-	
541	ETED	3 Suicide 8 Coul 4 Homicide deter	id not be rmined	building.	etc. (Spec	cify)	,, .	tion, tack	ory, orne		City or	Town, Ste	te)	er or Hurai H	oute Number,
O □ E E	PLE	29a. CERTIFIER	NG PHYSIC	CIAN: To the best of	my know	ledge, des	th occurre	d at the ti	me, date	and place, and du	e to the caus	e(a) and m	nanner as st	sted.	
SPITA ERAL In Tr. H	Σ														and manner as stated.
TO THE HOSPITA TO THE FUNERAL De filed within TE IMPORTANT: II	E C0	29b. SIGNATURE AND TITLE OF		7 /0/	^	1	NO	11de	41	20c. Ljemese jit			-	TE SIGNED	
5 5 8 W	00	Mon	//	tU6	In	ion	· K	in	_	000	793	0	-	4/2	1/93
	2	30. NAME AND ADDRESS OF PER	nsoy with	COMPLETED CAU	SE OF DE	ATH OTEM	27) (Type,	Politi)	102	SHE	PAUL	- 6	Laco	1	
		MARVINA	TE	FLOM	Ar	VA	10	7	131	etin	ou i	ud	21	202	_
_		31. DATE FILED (Month, Day, Year)	000	Julia Da	ATS SIGN	ATURE						- Andrews		-	
		APR 07 19	993	Trans was	7400v^	Mond	ALESTIC.								



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AL UK ALIENDING PHYSICIANT THE IAW REQUIRES THAT THE DEATH CENTRICATE DE EXECUTED WITHIN 24 FLUITS After DEATH. PAGE 6 May be retained by the hospital or a	AL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for us	2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
Ä	7	2	=

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO I. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF GEATH 3. TIME OF DEATH OAY OS 04 STEWART 1.:40 AM M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 1 M 2 TF 28 263-20-3025 YRS 01 72 21 N.CAROLINA 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR NORTH ARUNDEL HOSPITAL ASSOCIATION GLEN BURNIE A.A. COUNTY RESIDENCE OF DECEDENT 10d. INSIDE CITY
LIMITS 2...
1 YES 2 NO 10c. CITY, TOWN OR LOCATION MARYLAND ANNE ARUNDEL GLEN BURNIE FUNERAL 10a, STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21061 525 ARUNDEL AVENUE U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-11. MARITAL STATUS 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian Black, White, atc. 1 Never Married 2 Married If yes, specify Cuban, Mexican, Puerto Ri 1 YES NO Specify: BY 3 Widowed 4 Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) 12 BARMAID TAVERN 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) HERMAN TUCKER MAMIE TUCKER BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 525 ARUNDEL AVENUE-GLEN BURNIE, MD. WARREN E. STEWART 21061 20a, METHOD OF DISPOSITION 20b. PLACE AND OATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE 4 Donation 5 Ather Specify)

21. SIGNATURE OF FUNERAL SERVICE LICENSES CREMATORY, INC. 4/8 METRO CATONSVILLE.MD 22. NAME AND ADDRESS OF FACILITY RAYMOND C. FINK FUNERAL HOME 210 426 CRAIN HWY.S.W.GLEN BURNIE, MD. 21061 a 23. PART i. Enter the diseases of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition 30 Mins resulting in death) PLENSION CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2X NO 1 - YES 2 - NO PHYSICIAN: N/A 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF OEATH (Check only one) HOSPITAL:
1 A Inpatient 2 ER/Outpatient 3 DOA OTHER: 1 YES 2 NO me 5 - Residence 6 - Other (Specify) 27. MANNER OF OEATH 28a. DATE OF INJURY 28b. TIME OF 28c, INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending investigation 1 YES 2 NO BY 2 Accident
3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) COMPLETED 6 Could not be 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 K CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 96 29c. LICENSE NUMBER 29d. DATE SIGNED (Month Day, Year) 415173 uss D24862 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

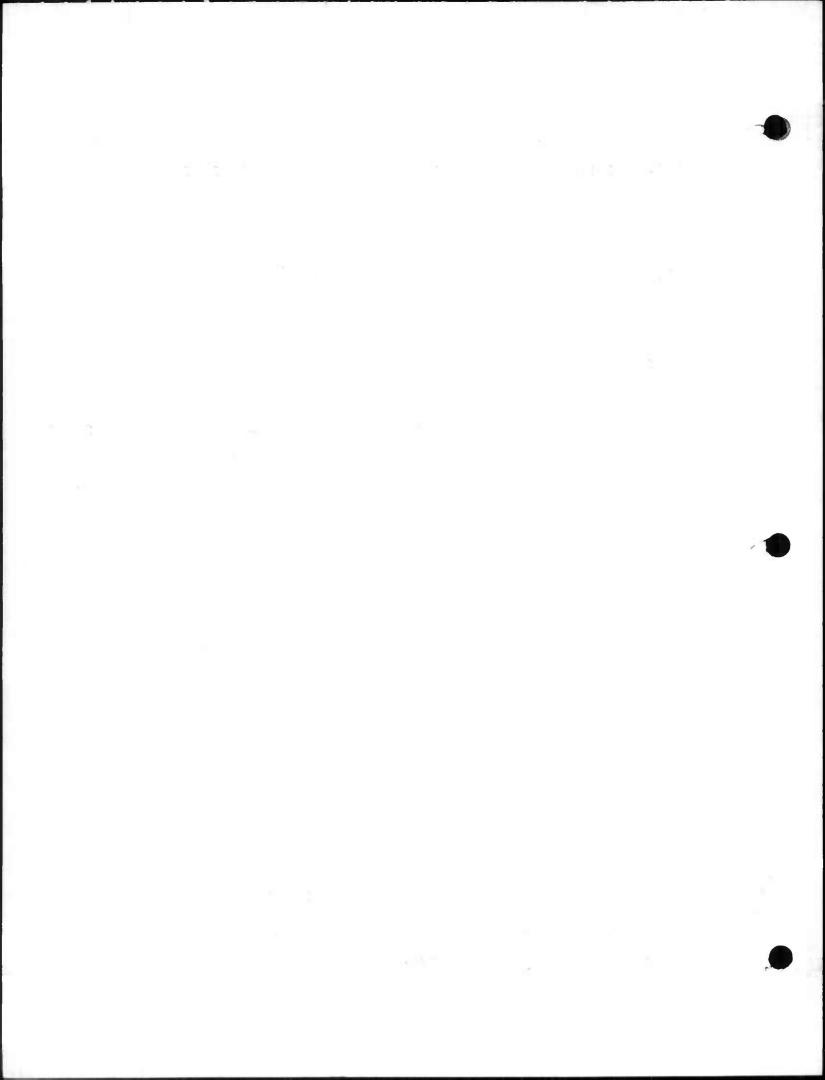
M.D./203 HOSPITAL DRIVE #300/GLEN BURNIE, MD. 21061

DAVID J.

TOLNER,

1993

32. REGISTRAR'S SIGNATURE Julia Davidson Bandese

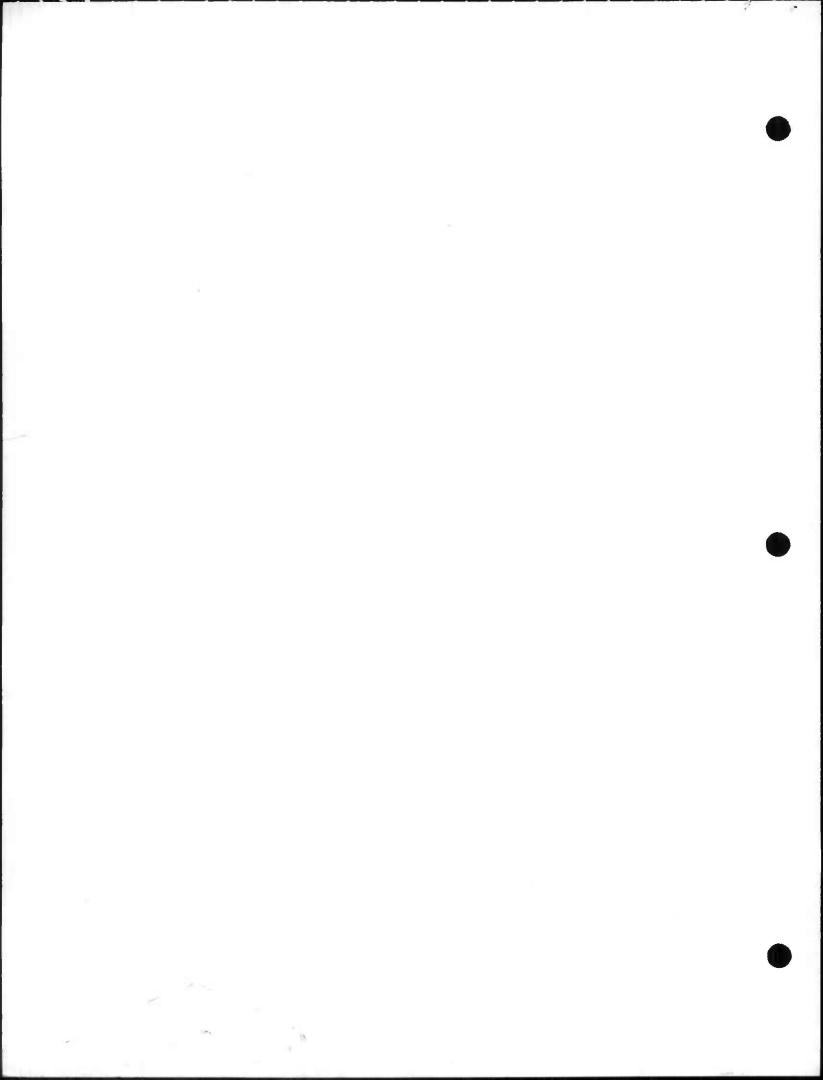


BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1 2 3 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND	D / DEPAR					MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATH MONTH D		YEAR	3. TIME OF DEATH
	RUBY	McCL				PSON	1	4 - 1		93	M
			7 O YRS.	MONTHS	DAYS	IF UNDER HOURS	24 HRS. MIN.	7. DATE OF BIRTH (Month, Day, Year) 8-25-19	122	8. BIRTH Country	PLACE (State or Foreign y) S.C.
DIRECTOR	99. FACILITY NAME (If not institution, give street UNION MEMORIAL	ŕ				R LOCATION		АТН	9c. COUN	TY OF D	
EG	RESIDENCE OF DECEDENT  10e. STATE  10b. COUNTY		10c. CIT	Y, TOWN OF	R LOCAT	ION					10d. INSIDE CITY
	MD 104. STREET AND NUMBER		F	BALT		RE					1 X YES 2 NO
FUNERAL	1830 E. 28th S	TREET			101.	212			1	S.	A .
B≺	11. MARITAL STATUS  1 Never Married 2 Merried  3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2X IF YES, GIVE WAR OR DATES	ABMED NO	It	yes, spe		n, Mexicen	C ORIGIN? (Specify Year, Puerto Rican, etc.)	or No-	Spech	- American Indian, , White, etc. by: BLACK
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade coll Elementary/Secondary (0-12)	TION (mploted) 16e. College (1-4 or 5 +)	Give kind of tifle. Do NOT us	vork done de	CUPATIO uring mos	N st of workin	g	16b. KIND OF BUS	SINESS/INDU		DIACK
MP	7th		DOME	ESTI	C						
	17. FATHER'S NAME (First, Middle, Last) Verge Hailey							Jane Bre			
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS	(Street a)			oute Number, City or Town		Codel	
임	DANIEL THOMPSON	í						ALTIMORE			218
	20a. METHOD OF DISPOSITION 1	If from State cemetery,	CEAND DATE	ther place)					CATION — C		
ı	21. SIGNATURE OF FUNERAL SERVICE LICEN	PEE /	NATIO			D ADDRES	ARK S OF FACE	ILAL IUTY	JREL /	MI	)
	> Dunis	S. frott						F.H./110			RTH AVE.
	23. PART I. Enter the diseases, or con ahock, or heart failure. Lis IMMEDIATE CAUSE (Final disease or condition resulting in death)	nplications that caused that tonly one cause on each i	death. Do r lina.	ot enter t	the mod	da of dyli	V	,		st,	Approximate Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A COM	USEQUENCE OF	are	ki	7	₽2	xare			
PHYSICIAN: MEDICAL C	PART II. Quee eignificant conditions of	contributing to death buying	ot resulting	n the unid	V	cause g	iven in P	PERFOR	MED?		WERE ALTOPSY FINDINGS MAIL ARLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2  NO
<u>¥</u>	25. WAS CASE REFERRED TO MEDICAL			_	26. PL	ACE OF DE	ATH /Chac	ik anly one)		_	
Sic		OSPITAL:	3 INOOA	OTHER:	1			Other (Specify)			
훉	27. MANNER OF DEATH	28s. DATE OF INJURY (Month, Day, Year)	28b. TiM		Br. INJU	TA YES		28d. DESCRIBE HOW IF	NJURY OCCI	JAED	
BY	1 Natural 5 Pending 2 Accident Investigation	albadestiest	1,310	M	1 🗌 Y	ES 2	NO				
	3 Suicide 6 Could not be 4 Homicide determined	28s. PLACE OF INJURY — At building, stc. (Specify)	t home, farm, a	treet, factor	ry, office			281. LOCATION (Street a City or Town, Stame)	nd Number o	r Aunul Ps	sule Mumber
COMPLETED		N: To the best of my knowledge,									
BE CC	29b. SIGNATURE AND TITLE OF CERTIFIER	100	111			~	NSE NUME			1	(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEATH (	4.000			DI	101	09	λ. 7	10	195
	31. DATE FILED (Month, Day, Yber)	32. REGISTRAD'S SIGNATUR	E	-0 C	N.	BA	4	71 171	HU	11	11) 212623
	APR 07 1993 Julia	Davidson-Randelle									



APR 07 199

1993

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours are death. Page 6 may be retained by the hospital or attending physician and completely filled in by the luminal director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

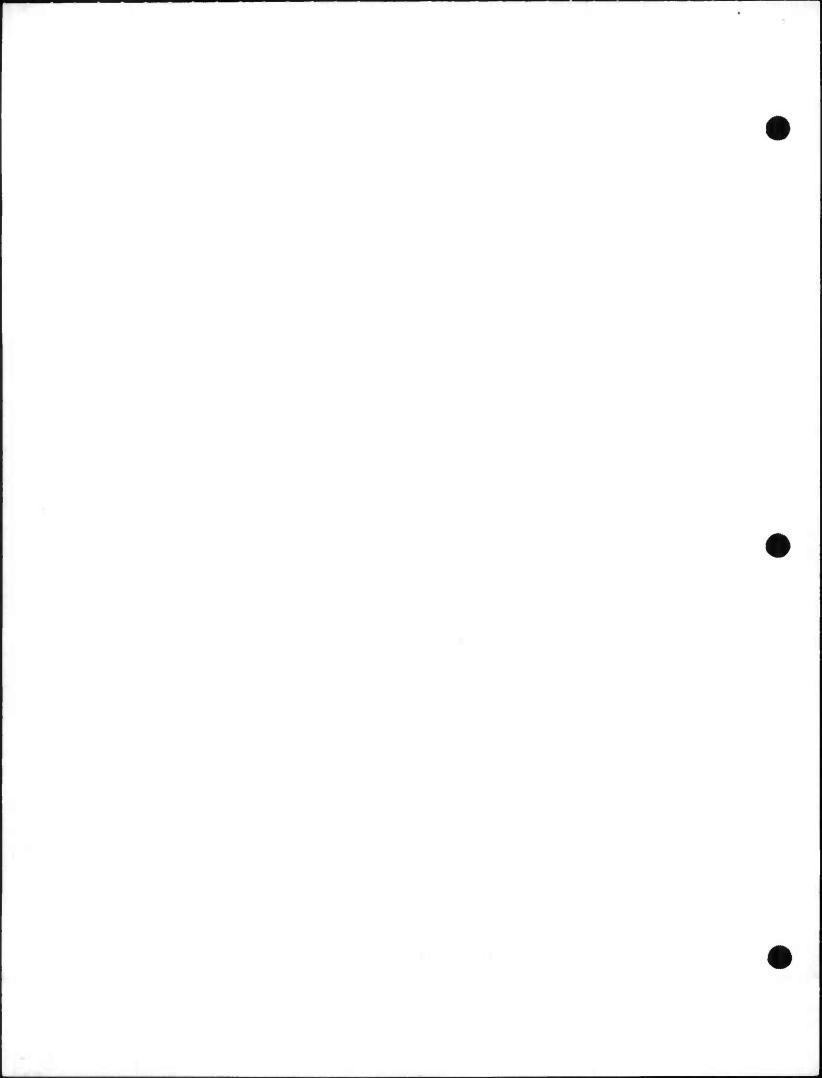
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the marker attention must be notified at once.

	B.K.S								13 09001
	1 - FOR REGISTRAR	STATE OF MARYLAND /	DEPAR	TMENT	OF HEAL	TH AND	MENTAL HYGIEN REG. NO		
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH	Aw	year 3. TIME OF DEATH
	GRAYLING NEL	SON TRUITT					04 02		93 7:20 A M
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (In yrs. las	st birthday)	IF UNDER t		IDER 24 HRS.	T DATE OF BURTH	1	8. BIRTHPLACE (State or Foreign
	211-46-3417	1 💢 M 2 □ F 3/4 58-	YRS.	MONTHS	DAYS HOU	NS MIN.	(Month, Day, Year) 1	958	Country)
	9a. FACILITY NAME (If not institution, give s	25-4		9b. CITY, T	OWN OR LOC	ATION OF D			M)
Œ.	2201 PINEWOOD	AVENUE		BAI	TIMO	RE C	ITY		THE SECTION OF SECTION
E	RESIDENCE OF DECEDENT					_			
DIRECTOR	10a. STATE 10b. COUNTY	1	10c. CIT	Y, TOWN OR	LOCATION				10d. INSIDE CITY
5	MD		В	altin	nore				LIMITS?
FUNERAL	10e. STREET AND NUMBER				10f. ZIP C	ODE		10g. CITIZ	ZEN OF WHAT COUNTRY?
8	602 Brune St.				212	12		US	S A
3	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. AR	MED	13. W	S DECENDEN	T OF HISPAI	NIC ORIGIN? (Specify Yes		14. RACE — American Indian
	1 X Never Married 2 Married	FORCES? 1 YES 2 X N IF YES, GIVE WAR OR DATES	<b>NO</b>	lf )	yes, specify C	uban, Mexica	in, Puarto Rican, atc.)		Bleck, White, etc.
ВУ	3 Widowed 4 Divorced			1	_ · 7\\_A	Ороси	,		<sup>Specify</sup> Black
	15. DECEDENT'S EDUC (Specify only highest grade	CATION 16a. DE completed) (G	CEDENT'S	USUAL OCC	UPATION ring most of we	ndrina	16b. KIND OF BUS	SINESS/IND	USTRY
9	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Do NOT us	e retired.)		a rong			
₩ M	9th	Un	emp	loyed	<u>d</u>				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. M	OTHER'S NA	ME (First, Middle, Maiden	Surname)	
ш	Robert Truitt	•			H	ilda	Payne		
TO B	19a. INFORMANT'S NAME (Type/Print)	191	b. MAJLING	ADDRESS (	Street and Nun	nber or Rural	Route Number, City or Tow	n, State, Zip	Code)
F	Hilda Eady	3	320 I	Reed	St./	Erie	, PA 1650	7	
	20a. METHOD OF DISPOSITION 1 (X) Burlet 2 Cremetion 3 Remo	20b. PLACE	AND DATE	OF DISPOSITI	ION (Name of				City or Town, State
	4 Donation 5 Other (Specify)	oval from State	Mem	or i a 1	Par	k	Rar	dall	Istown, MD
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		22. NA	ME AND ADD	RESS OF FA			
	► Q1	4 1		LIM	c M	ADCII	F II /110	1 -	NORTH
	23. PART L/Enter the disesses, pro	pompiloations that arrived the	-41 0-	W iVI	C. M.	АКСП	г.п./110	I E.	NORTH AVE.
	shock, or heert fellure.	Liet pniy one ceuse on eech ilne	eth, UD r	Dt enter tr	ne mode DI	dying, suc	h es cerdiec or respi	ratory em	est, Approximate intervsi Between
	iMMEDIATE CAUSE (Finel disease or condition	M 11 1	1	/	111	,	1		Onset and Death
	resulting in death)	DUE TO (OR AS A CONSEC	Gu	nsho	TW	ounc	15		
		DUE TO (OR AS A CONSEC	DUENCE OF	7):					
ERTIFICATION	Sequentially list conditions,	DUE TO (OR AS A CONSEC	NIENCE OF						
ATI	if any, lesding to immediate cause. Enter UNDERLYING	DOE TO JOH AS A CONSEC	20ENCE UI	-):					
윤	CAUSE (Disesse or injury	DUE TO (OR AS A CONSEC	LIENCE OF						
Ē	that initieted events resulting in death) LAST		*OE110E O1	,.					i
		1							
4	PART ii. Other eignificent condition	s contributing to deeth but not re	eeulting i	n the unde	erlying caus	e given in	Part i. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS
MEDICAL							PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE
밀							1/KLYES 2	NO	OF DEATH?
3									1/SLYES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL			-	28. PLACE OF	E DEATH (C)			
S	EXAMINER?	HOSPITAL:		OTHER:					
¥	27. MANNER OF DEATH	1 Inpatient 2 ER/Outpatient 3  28s. DATE OF INJURY	28b, TIM	-	g Home 5 []		8XIX ther (Specify)		
	1 Natural 5 Pending	(Month, Day, Year)	INJ	URY M	WORK?		28d. DESCRIBE HOW II	NJURY OCC	URED
BY	2 Accident Investigation	04-02-93 28e. PLACE OF INJURY — At hor			1 YES	Z [] NO	SUBJECT	100 10 10 10	
	3 Suicide 8 Could not be 4 Homicide detarmined	building, atc. (Specify)		L YA			281. LOCATION (Street a City or Town, State)	ind Number (	or Rural Route Number,
ᄪ							2201 pin		
重		CIAN: To the best of my knowledge, dea							
COMPLETED	one) 2 MEDICAL EXAMINE	R: On the basis of examination and/or is	nvestigatio	n, In my opir	nion, death oc	cured at the	time, data and place, an	d due to the	cause(a) and manner ea stated.
Q	29b. SIGNATURE AND TIFLE OF CERTIFIER	Λ			I 20- 4	JCENSE NU	ABED I	29d DATE	SIGNED (Month, Day, Year)
ш		11 // // .			29C. L	TCEMPE MAIN	HOEK I		SIGNED (MORRI, Day, 1681)
TO BE	Donni	J. Chut us				D, C.N			- 02 - 1993

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32. REGISTRAR'S SIGNATURE Devidson

PENN STREET BALTIMORE, MARYLAND 21201



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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

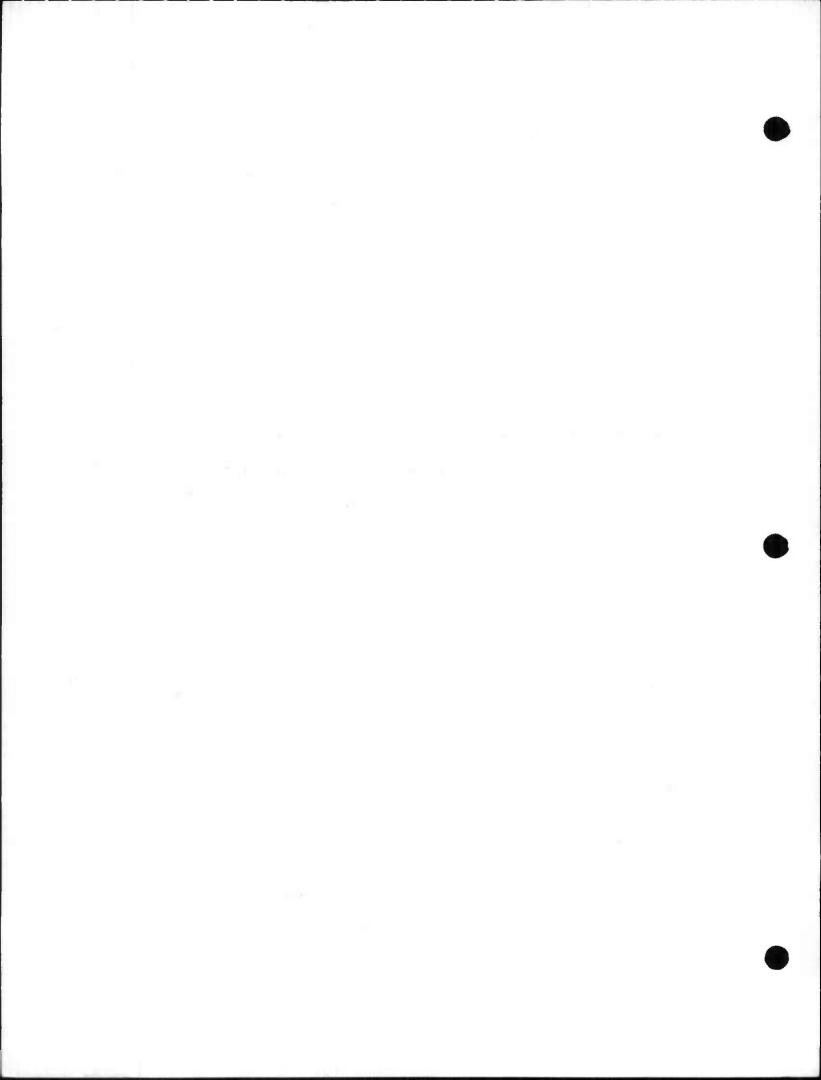
BALTIMORE, MARYLAND 21215-0020

TO BE THENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

To hours after death. Page 6 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be the marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTA	L HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	1. OECEDENT'S NAME (First,	Middle, Last)			_						OF OEATH			3. TIME OF DEATH
	LOUIS C									04 02 1993			VEAR	0150 A M
- 3	4. SOCIAL SECURITY NUMBER	ER	5. SEX	6. AGE (In yn	s. last birthday)	IF UNC	DER 1 YEAR	R IF UNDE	R 24 HRS.	7. DATE	OF BIRTH	1	S. BIRT	HPLACE (State or Foreign
	407-03-920	)2	1 🔀 M 2 🗌 F	7	4 YRS.	MONTH	S DAY	HOURS	MIN.	(Month	18 1	010	Count	try)
- 1	9s. FACILITY NAME (If not ins	titution, give st	reet and number)			9b. CI	TY, TOW	N OR LOCAT	ION OF D		10 1	919 9c. COU	NTY OF D	entucky DEATH
5	GREATER BA	LTIMO	RE MEDIC	AL CEN	TER		TOWS	ON				777 3745	-	
ธี	RESIDENCE OF DECEDENT							TOWSON BALTIMORE					IOKE	
DIRECTOR		10b. COUNTY			10c. Cl	TY, TOWI	N OR LO	CATION						10d. INSIDE CITY LIMITS?
	MARYLAND	BAL	TIMORE		E	BALT	IMOF	RE						1 ☐ YES 24X NO
₹ I	10e. STREET AND NUMBER							10f, ZIP CO	DE			10g. CIT	IZEN OF	WHAT COUNTRY?
FUNERAL	1415 JEFFE	ERS RO	AD				- 1	212	204			τ	J.S.	Α.
5	11. MARITAL STATUS  1 Never Married 2 X I		12. WAS OECEDEN			1	3. WAS D	ECENDENT specify Cub	OF HISPAI	NIC ORIGIN	? (Specify Yes		14. RAC	E — American Indian, k, Whits, etc.
B	3 Widowed 4 Divon	101/10/10	IF YES, GIVE Y					ES 2 NO			incari, etc.)		Spec	
		DENT'S EDUC	PATION	1										White
	(Specify only	highest grade	completed)		(Give kind of life. Do NOT u	work don	ne durina	TION most of work	ing	16b.	KINO OF BUS	INES\$/IN	DUSTRY	
וה	Elementary/Secondary (0-	12)	College (1-4 or 5	·						- 1				
COMPLETED	17. FATHER'S NAME (First, Mic	frite ( eet)	4		Claims	Dep	ot.						cvice	es Adm.
								16. MO			liddle, Malden			
8	19a. INFORMANT'S NAME (Ty		. Tharp		105 MAIL IN	C ADDRE	EPP /Pres	t and Musel			er, City or Town			
2			ml		TOOL MAILING					noute Numb	er, City or lowi	1, Stere, Zg	C000)	
	Mrs. Antoing	ON		20b PL 4	CE AND DATE		_	e as	Tue	OATE	20- 10	ATION	Ola	own, State
	1 ☑ Burisi 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (		wat/from State	cometary	, crematory or o	other plac	ce)			1				
	21. SIGNATURE OF FUNERAL		oksky /	10012	aney V			AND ADDR			9B T:	Lmon	Lum	, Md.
	1/ 1/	601		1/							50 Yo	ck Ro	1. 2	1204
	23. PART I. Enter the dis	A	affer	di-		F	Ruck	Tows	on F	unera	1 Home	e, Ir	nc.	
NOI	iMMEDIATE CAUSE (Fine disease or condition resulting in death)  Sequentially list condition if any, leading to immediately in the condition in	el bons, C	DUE TO	RDIOPU (OR AS A COR D STAG (OR AS A COR	LMONAR	PF):	RRES	T				_		interval Between Onset and Death
CERTIFICATION	cause. Enter UNDERLYIN CAUSE (Disease or injur- that initiated events resulting in deeth) LAST	ig y	ļ	(OR AS A CON										
4	PART II. Other significen		contributing to	death but n	ot resulting	in the	underly	ing ceuse	given in	Part i.	24a. WAS AN		24b	. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
EDICAL	PNEUMONI	A									1 YES 2			COMPLETION OF CAUSE OF DEATH?
M M										_ [				1 TES 2 NO
ź														
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEOICAL	HOSPITAL:					PLACE OF I	DEATH (Ch	eck only one	)			
2	1 TES 2 NO		12 Inputient 2	ER/Outpetien	M 3 DOA	OTHI 4 □ N		ome 5 🗆 A	esidence	6 🗆 Other	(Specify)			
5	27. MANNER OF DEATH		28s. DATE OF (Month, D		28b. TIN	NE OF	28c. I	NJURY AT		28d. DE\$6	CRIBE HOW IN	JURY OC	CURED	
	1 Natural 5 P	ending westigation				М		YES 2 [	NO					
		ould not be	28s. PLACE O building,	F INJURY — A atc. (Specify)	t home, farm,	street, fa	ectory, of	lics		28f. LOCA	TION (Street ser Town, State)	nd Number	or Rural i	Route Number,
	4 Homicide de	etermined	C. J. C. C.											
COMPL	29s. CERTIFIER (Check only	FYING PHYSIC	AAN: To the best of	my knowledge	, death occurr	ed at the	e time, de	ite end place	, end dus	to the caus	e(s) and man	ner es stat	ed.	
5														s) and menner as stated.
۲ ا	296 BIGNATURE AND TITLE OF	CERTIFIER	rodie	AU	D		<del></del>	29c, LIC	ENSE NUM	MBER		29d. DAT	E SIGNED	(Month, Day, Year)
2	30. NAME AND ADDRESS OF	PERSON WHO	hoche	SE OF DEATH			01	NIC	100	0/00		root	17 V C	atto MD 2120
	31. DATE FILED (MONT) POPON	3' 3		R'S TENATUR		6/	U	10.(	V!U	rie:	>. DTV	eel	10	4110 MV 6124
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FOR STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S RAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR MON 9. Joseph M. Valcourt 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday)
68 YRS. 5 SEX IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS 8. BIFTHPLACE (State or Foreign 05/06/24 212-20-4648 1 M 2 5 Pennsylvania use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Mercy Hospital Baltimore RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. Howard Hanover 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6402 Hanover Road 21076 USA 24 hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 1 Never Married 2 Marrie BY 3 Widowed 4 Divorced IIWW white COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL, OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 166. KIND OF BUSINESS/INDUSTRY (Specify only highest grade compl Elementary/Secondary (0-12) College (1-4 or 5+) detached for 12 Technical Associate Westinghouse 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 70 Cyril H. Valcourt director, page 5 should be BE Rose A. Valcourt notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဝ Mary E. Valcourt 6402 Hanover Rd., Hanover, 21076 Md. pe 20a. METHOD OF DISPOSITION

1 Burlal 2 Cremation 3 Re
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE must 4/08 Crownsville. Md. Crownsville Veterans Cem. 21. SIGNATURE OF PUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY
Gary L. Kaufman Funeral Homes the funeral 5695 Main St., Elkridge, filled in by the fi Md. 21227 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate IMMEDIATE CAUSE (Final Onset and Death cremation, other traumatic event, the disease or condition\_ 25PIZATOZY TAIL completely executed within resulting in death) DUE TO (OF AS A CONS QUENCE OF): burial, KA OG SA CERTIFICATION bein signed by the attending physician and 1 20 U. Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF if any, leading to immediate cause. Enter UNDERLYING g equires that the death certificate CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 6 Injury, PART U. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS MAJLABLE PRIOR TO COMPLETION OF CAUSE shows any 2 701 1 YES 2 NO OF DEATH? 1 TYES 2 T NO PHYSICIAN: Nept by ž S 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) 2 tem 룅 HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 YES 2 1 100 5 - Residence 8 - Other (Specify) ä Ħ 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW THURY OCCURED 1 Matural 5 Pending Investigation BY 1 YES 2 NO 2 Accident 26s. PLACE OF INJURY — bullding, etc. (Specify) 3 Sulcide At home, farm, street, factory, office 281. LOCATION (Street and Number of Rural Route Number City or Town, State) COMPLETED 8 Could not be DIRECTOR 4 Homicide 28 Mours tem 8 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, dets and place, and due to the cause(s) and manner as stated. FUNERAL Within 72 I IMPORTANT: II 2 MEDICAL EXAMINEF. On the bagis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29d. DATE SIGNED (Month, Day, Year) BE 出土 3 JM SPEC. B 9 3014 223 2 EO CAUSE OF GEATH (ITEM 27) BODAC 20215 ZOU 12 REGISTRARIS SIGNATURE '31. DATE FILED (Month, Day, Year) 1993

Same and the same and 

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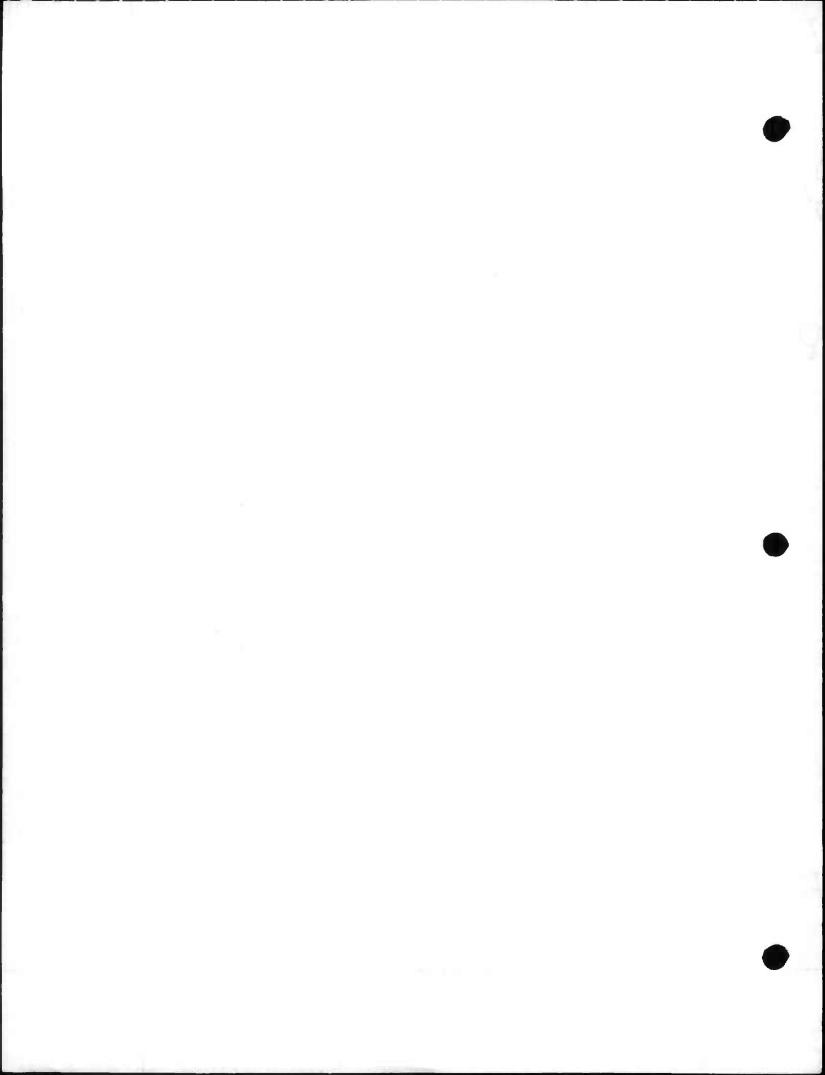
## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

			ICATE						
))	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF			T	3. TIME OF DEATH
3	DANIEL AVERY WH	ITFIELD			монти 04	04 DAY	1993	YEAR	
	71.211				04 04 1993				6:47 P M
	4. SOCIAL SECURITY NUMBER 5. SEX 6	. AGE (In yrs. last birthday)	IF UNDER 1 YE		7. DATE OF	HRTH 8. BIRTHPLACE (SI			PLACE (State or Foreign
	213-31-2931 1⅓™2□₽	2 YRS.	MONTHS D	YS HOURS MIN.	(Month, De	18-9	_ I	Country) M D	
1	213-31-2331 -					10-9			
	9e. FACILITY NAME (If not institution, give street and number)		9b. CITY, TO	WN OR LOCATION OF D	EATH		9c. COUN	TY OF DE	ATH
E	THE JOHNS HOPKINS HOSPITA	1	RA1	TIMORE		ļ	рлі	TIMO	RE CITY
2	RESIDENCE OF DECEDENT	L .	DAL	THUKE			DAL	LIMO	KE CIII
DIRECTOR	10a. STATE 10b. COUNTY	100 00	Y, TOWN OR L	OCATION				Т	and minima e-
Œ									10d, INSIDE CITY LIMITS?
<u>a</u>	MD CM	Ba	Itimo	re					1X YES 2 NO
	10e. STREET AND NUMBER			10f. ZIP CODE		T	10a CIT11		HAT COUNTRY?
2	1001 0 4 4 13 3					[	-		IIAI COURTRIT
Ш	<u>1901 Oakhill Ave.</u>			21218			U.S	SA	
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT B	EVER IN U.S. ARMED	13. WAS	DECENDENT OF HISPA	NIC ORIGIN? /S	pecify Van	or No T	14. RACE	- American Indian.
	1 Nover Married 2 Married FORCES? 1	YES 2 NO	If yo	s, specify Cuban, Mexic	an, Puerto Rice	n, etc.)		Black,	White, atc.
BY	3 Widowed 4 Divorced IF YES, GIVE WAR	OR DATES	1 🗆	YES 2 NO Speci	ly:			Specifi	flack
							- 1	E	rack
ШI	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S	USUAL OCCU	PATION	16b. KIP	D OF BUS	NESS/IND		
	Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind of Ille. Do NOT u	work done durir se retired.)	g most of working					
7		ah	:1d						
Σ	child	CII	ild						
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		h	18. MOTHER'S NA	AME (First, Midd	le, Maiden S	Sumame)		
	Michael Whitfield Sr			April	0'Ne	a 1			
H	19a, INFORMANT'S NAME (Type/Print)								
၉	SECURATED OF MANAGEMENT			reet and Number or Rural					
	April O'Neal	510	E. 26	th St./B	altim	ore.	MD	212	218
- 1	200. METHOD OF DISPOSITION	20b. PLACE AND DATE			DATE	· ·	ATION — C		
- 1	XLX Burial 2 Cremation 3 - Removal from State	corpetery, crematory or o	of bisrusification there place).	n (Nama or	DATE				
- 1	4 Donation 5 Other (Specify)	King Me	moria	1 Park		Kan	dal	Isto	wn, MD
- 1	21. SIGNATURE OF FUNERAL SERVICE MICHISAL		22, NAN	E AND ADDRESS OF F	ACILITY				
		Ω							
	KILLMAN D Leat	X	WM	C. MARCH	F.H.	/110	1 E.	. NC	RTH AVE.
	23. PART I. Enter the diseases, or complications that o	reused the death. Do							
- 4	shock, an heart failure. List only one cause	on each line.	not enter the	mode of dying, suc	en as cardiac	or respir	atory arm	est,	Approximata intervai Between
- 1	IMMEDIATE CAUSE (Final							10.	Onset and Death
	disease or condition	DICOL	Dug	C			- 1	1 20	2 20 (32
- 1	discuss of condition	VEGOVEL	LATIN !						
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	resulting in death) a. DUE TO (or	R AS A CONSEQUENCE O	PUKN	1>			1 (	Chr.	
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,



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BALTIMORE, MARYLAND 21215-0020	ith. Page 6 may be retained by the hospital or attending physician.	neral director, page 5 should be detached for use as the burial-transit page
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VISION OF VITAL RECORDS, P.O. BOX 68760,	ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician.	ECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit and state death with the State Dark of Banking and Mental Mariana price in burial promotion, or removed
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 2. DATE OF DEATH 3. TIME OF DEATH AMES WATSIC PANKLIN 2:45 AM 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS 216-10-8688 1 X M 2 | F Baltimore, 90. FACILITY NAME (If no 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH BALTIMORF 700 A N/A RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10d. INSIDE CITY n/ N/A Baltimore City 1 YES 2 NO FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4311 Raspe Avenue 21206 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 12 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indien, Black, White, etc. 1 Never Married 2 Merried If yes, specify Cuban, Mexicen, Pu BY 1 TES 2 NO Specify: Specify: White 3 . Widowed 4 Divorced WWIT COMPLETED 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor Pittsburg Plate Glass examiner must be notified at once. 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) James Watsic BE Barbara Gertrude Tochterman 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna C. Watsic 4311 Raspe Avenue, Baltimore, Maryland 21206 20s. METNOD OF DISPOSITION
1 M Buriel 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) DATE 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State metery, crematory or other place)
Parkwood Cemetery Baltimore. Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY John C. Miller, Inc. athle. 6415 Belair Road, Baltimore, Maryland 21206 the medical 23. PART LEnter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between IMMEDIATE CAUSE (Finel **Onset and Death** disease or condition resulting in death) 23 shows any injury, or other traumatic event, DUE TO (OR AS A CONSEQUENCE OF) DRONARY MEDICAL CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO OF DEATH? 1 TYES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? Hem 28. PLACE OF DEATN (Check only one) OTHER 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA e 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DEŞCRIBE NOW INJURY OCCURED is marked, 1 Netural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY - At home, farm, street, factory, office 3 Suicide 8 Could not be 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 28 4 Nomicide TO THE HOSPITAL OR AT
TO THE FUNERAL DIRECT
be filed within 72 hours a
IMPORTANT: If Item 2 DIRE 29e. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the firm, data end piece, and due to the cause(e) and manner as stated. 2 MEDICAL EXAMINER: On the beels of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dus to the cause(e) and manner ee stated 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER MIHIXU 04 93 06 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) (500 K)

32. REGISTRAR'S SIGNATURE R = 7 1993

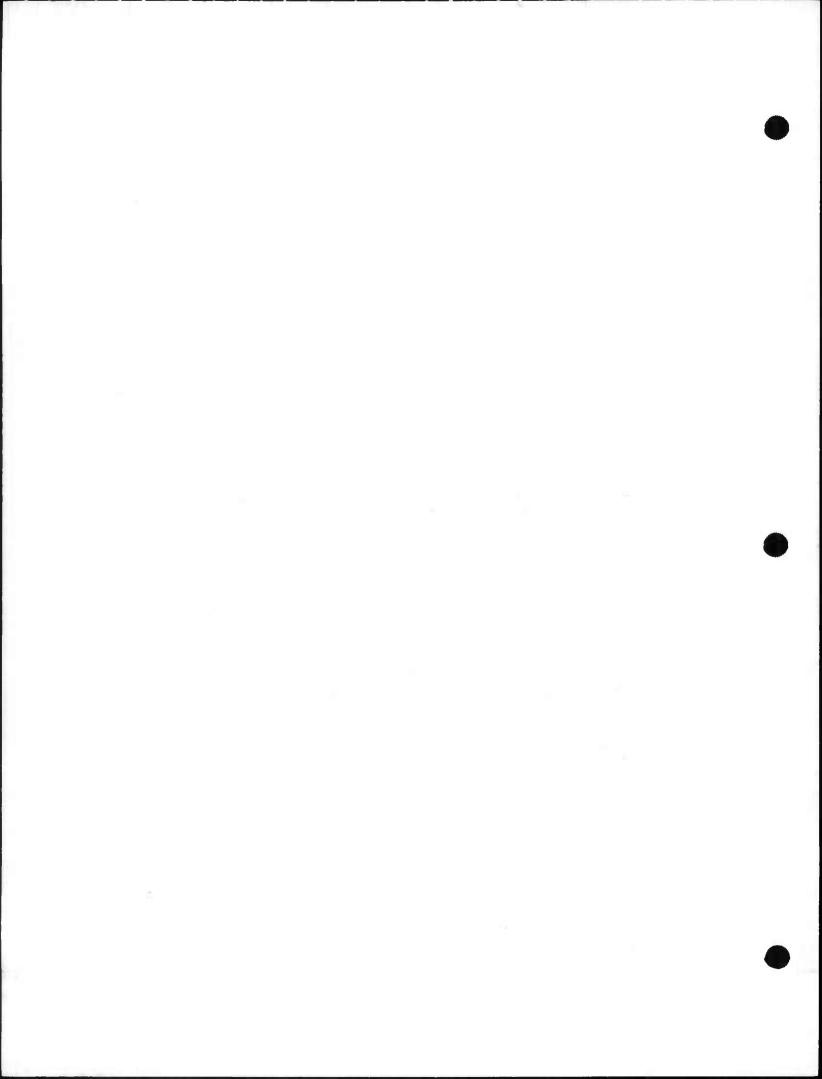
31. DATE FILEDY (Month: Day Ann

DHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netitled at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF				NTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)  JOSEPH M		W	ALKER,	SR		DATE OF DEATH	av (	9 SEAR	3. TIME OF DEATH 5:40 PM	
ý	4. SOCIAL SECURITY HUMBER 218 14 0405	MONTH OF THE PROPERTY OF THE P					924	BIRTHPLACE (State or Foreign Country)     Marvland			
TOR	99. FACILITY HAME (If not institution, give st  NORTH ARUNDEL HOS  RESIDENCE OF DECEDENT		IATION		N BURN	ON OF DEATH		9c. COU	NTY OF D		
DIRECTOR	10a. STATE 10b. COUNTY	Arundel	10c. CiT	Y, TOWN OR L		Pasade	ena			10d. INSIDE CITY LIMITS? 1  YES 2 XXNO	
FUNERAL	100. STREET AND NUMBER 764 224th St.				101. ZIP COD	_				zen of what country? ted States	
ВҰ	11. MARITAL STATUS 1 Never Married 2XXMerried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 X YES IF YES, GIVE WAR OR D. WORLD WAR I	2 NO	If ye	DECEMBENT ( s, specify Cube YES 2 HO	m, Mexican, Pr	PRIGIH? (Specify Yas verto Rican, etc.)	or Ho-	14. RACE Black Speci	American Indien, c, White, etc.	
COMPLETED	15. DECEDEHT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed)  College (1-4 or 5+)	Me. Do NOT us	vork done durin	PATION g most of worki	ng	16b. KIND OF BU	Resta		nt	
	17. FATHER'S NAME (First, Middle, Last)  Cary Ed	lward	Walke			HER'S NAME (	First, Middle, Meiden	Surname)		trickline	
TO BE	19m. INFORMANT'S NAME (Type/Print)  E. Regina Walker		19b. MAJLING	ADDRESS (Str	eet and Number	or Rural Route	Number, City or Tow		Code)	CITCRITTE	
	20e. METHOD OF DISPOSITION  1 1 Burlel 2 Cremation 3 Remo	oval from State Cerr	PLACE AND DATE O	OF DISPOSITIO	DSITIOH (Name of DATE 20c. LOCATION — City or Town, State						
	21. SIGNATURE OF PUNERAL SERVICE LICE		101y CLOS	22. HAM MC	E AND ADDRE	ss of facilit Funera		of Pas	sadei	na	
COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	IMMEDIATE CAUSE (Finel disease or condition resulting in death)  Sequentisity list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II Caher significant denditions resulting in death) LAST  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 MO  27. MANNER OF DEATH  1 Predicted Investigation of Death  1 Production of Death  1 Production of Death  1 Production of Death  1 Certification of Death  1 Description of Death  290. CERTIFIER (Check only)	DUE TO (OR AS A  DUE TO (OR AS A  DUE TO (OR AS A  DUE TO (OR AS A  DUE TO (OR AS A  DUE TO (OR AS A  EXAMPLE TO (OR AS A)  AS A  DUE TO (OR AS A)  DUE TO (OR AS A)  EXAMPLE TO (OR AS A)  AS A  DUE TO (OR AS A)  DUE TO (OR AS A)  DUE TO (OR AS A)  DUE TO (OR AS A)  DUE TO (OR AS A)  DUE TO (OR AS A)  DUE TO (OR AS A)  DUE TO (OR AS A)  DUE TO (OR AS A)	ach line.  If we have a consequence of consequence of consequence of consequence of consequence of a consequence of consequenc	or the under the surface of the surf	ying cause	EATH (Check o	1. 24a. WAS AN PERFOR 1 YES 2 Other (Specify)  Describe How in City or Town, State)	AUTOPSY MEO?  NO  NJURY Occurred Number	24b.		
TO BE CO	30. NAME AND ADDRESS OF PERSON WHO JUAN A BELTRAN	Dr.	ATH (STEM 27) (Type OAKWOOD	Prints	29c. LICE	NSE HUMBER	-63	29d. DATE	F / C	Manufaction (Manufaction)  Manufaction (Manufaction)  LAND 21061	
	APR 07 1993	pana Davidson-19	Marine								



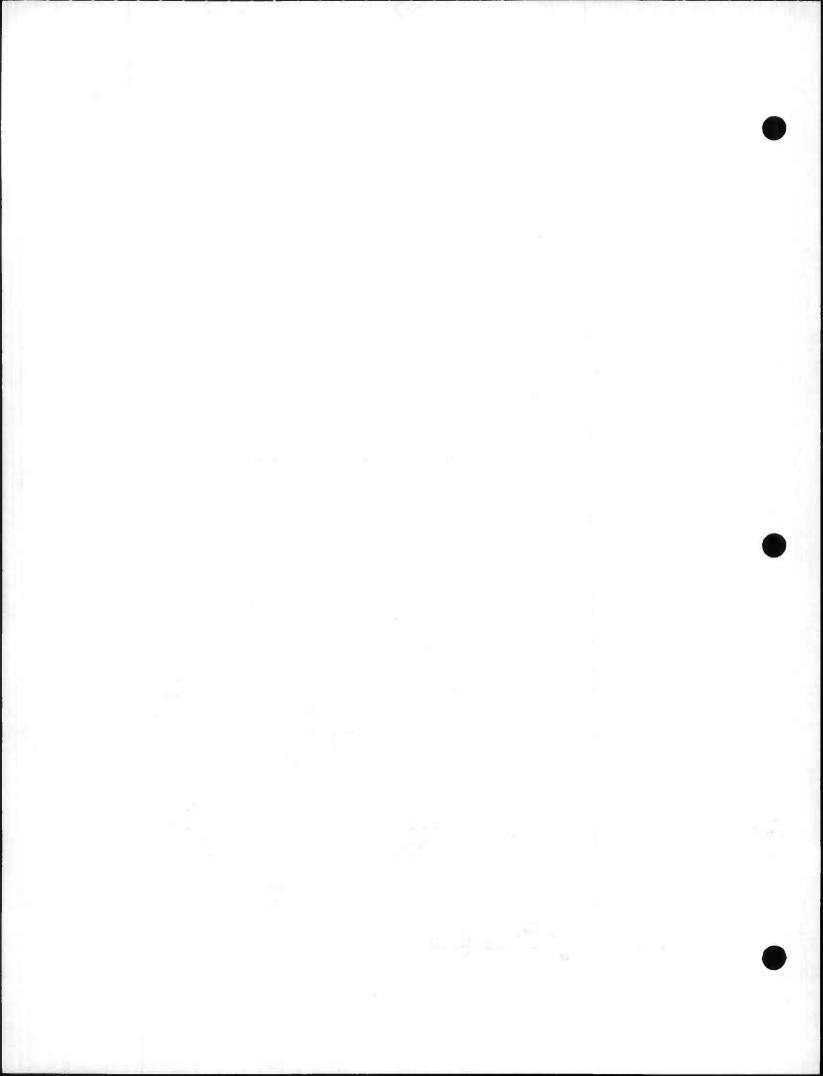
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-	Dags & may be present
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ISION OF VITAL RECORDS, P.O. BOX 68760, reduires that the death certificate be ATTENDING PHYSICIAN: The law

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	Each: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 show	research with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH WEIKINGE 3. TIME OF DEATH YEAR AN 21 NGER 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last bi 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign (Month, Day, Year) May 22,1897 578-05-2283 1 M 2 | F 97 Germany permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 5 DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10c, CITY, TOWN DR LOCATION IOd. INSIDE CITY Maryland Baltimore Towson 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Horncrest burial-transit Road 21204 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No. If yea, specify Cuban, Mexican, Puerto Rican, etc.)

1 
YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 2 ND 1 Never Married 2 Married BY 3 Widowed 4 Divorced the White 38 COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY nse (Specify only highest gr Ď Elementary/Secondary (0-12) College (1-4 or 5+) detached Butcher Meat Market 12 yrs 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN Joseph 8 be notified at Weikinger Margaret BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Charlotte W. Pine 607 Baltimore Avenue Towson, Maryland 21204 20a, METHOD OF DISPOSITION
1 Burlal 2 Cremation 3 Ram
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Stata OATE must Hilltop Service Corp. 4/4/93 Towson, Maryland examiner 21. SIGNATURE OF FURTHERAL SERVICE LIQ 22. NAME AND ADDRESS OF FACILITY 1050 York Road Towson, Md. Ruck Towson Funeral Home, Inc. a or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, medical 23. PART I. Enter the dipel Approximate Interval Between shock, or heart fell IMMEDIATE CAUSE (Final Onset and Death the disease or condition resulting in death) mar 2 WKS event, DUE TO (OR AS A CONSEQUENCE OF) 205 28 is marked, or item 23 shows any injury, or other traumatic MEDICAL CERTIFICATION Sequentially list conditions, OUE TO (DR AS A CONSEQUENCE OF If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury OUE TO (OR that initiated events resulting in death) LAST PART II. Other significant conditions contributing to deeth/but not resulting in the underlying cause given in Part 1. 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY 1 YES 2 NO OF DEATH? 1 TES 2 NO BY PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 Dispatient 2 ER/Outpatient 3 DOA OTHER: 1 YES 2 NO ne 5 🗆 Residence 6 🗆 Other (Specify) 4 🗆 Nun 27. MANNER OF DEATH 28c, INJURY AT WORK? 28a. DATE DF INJURY 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO 2 Accident 28s. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number City or Town, State) 8 Could not be COMPLETED 4 Homicide Item 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE FUNITION DE filed with INTERNATION IN INTERNATION IN INTERNATION IN INTERNATION IN INTERNATION IN INTERNATION IN INTERNATION IN INTERNATION IN INTERNATION IN INTERNATION IN INTERNATION INTERN 2 MEDICAL EXAMINER: On the on and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and my THE HOS THE FUIN 29c. LUCENSE NUMBER
D16389 BE 2 ED CAUSE OF DEATH (ITEM 27) (Typ 17 16 HARTORD Rd Rm106 MO · VALARAO



1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		***************************************			<u> </u>	ICAIE	<u> </u>	DEA	* *		REG. NO.			
		1. OECEDENT'S NAME (First, Middle, Last)								2. DATE OF			3	TIME OF DEATH
		EDNA T. WALDM	AN							MONTH 04	01	1993	YEAR	8:00 P M
		4. SOCIAL SECURITY NUMBER	5. SEX	A ACE (la	rs. last birthday)	F 400000 4								
				100		IF UNDER 1	DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF (Month, L	BIRTH Day, Year)	1	B. BIRTHPL: Country)	ACE (State or Foreign
9		113-01-7430	1 🗆 M 2 🔀 F	77	YRS.					11	27 1	915		v York
should		9a. FACILITY NAME (If not institution, give s	treet and number)			9b. CITY, 1	TOWN O	OR LOCATIO	N OF DE				TY OF DEAT	
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T.	片	MARYLAND BA	LTIMORE	•		m o	1 E-2 CT /	0.17						LIMITS?
permit.		10e. STREET AND NUMBER	DITHORD		TOWSON						1 🗆 YES 2 🕞			
	3AL						101.	. ZIP CODE				10g. CITIZI	EN OF WHA	T COUNTRY?
020 physician. burial-transit	ER	730 CAMBERLEY	CIRCLE	#C6				212	04			II.	S.A.	
020 physician burial-tra	FUN	11. MARITAL STATUS	12. WAS DECEDEN							IIC ORIGIN? (		7	4. RACE -	American Indian,
		1 Never Married 2 Married	FORCES? 1					ecity Cubar 2 P NO		n, Puerto Ric	en, etc.)		Specify:	fhita, atc.
the diag	B	3 🙀 Widowed 4 🗌 Divorced	11.			_   _ '		K	ороспу	•				nite
1215-0 r attending use as the	유	15. DECEDENT'S EDUC		16	a. DECEDENT'S					16b, K	NO OF BUS	INESS/INDU		11.00
21. 21. 22. 22. 24.	ᇤ	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5		(Give kind of a life. Do NOT us	vork done du se retired.)	iring mos	st of working	7					
ND 2 hospital ached to	립	12	college (1-4 of 3	''	Hom	e Mak	0.36				Own	IIomo		
AND the hospits detached once.	COMPL	17. FATHER'S NAME (First, Middle, Last)			HOIII	e Man	er							
LA de the	8							18. MOTH	ER'S NAI	ME (First, Mid	dle, Maiden :	Sumama)		
d by the deat	H	William J. The	omoson					Er	nily	Ste	ewart			
MAR retained 5 should notified	2	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	AODRESS (	Street a	nd Number	or Rural F	Route Number,	City or Town	, State, Zip C	ode)	
5 5 5 E	۱۴	Mrs. Violet Thom	nson			Sam	A 3	s 10e	2					
RE, may be x. page		20a. METHOD OF DISPOSITION		20b PL	ACE AND DATE					DATE	200 100	CATION — CI	the on Young	Plants
FIMOR Page 6 ma al director, p		1 Buriel 2 Cremation 3 Remo	oval from State	cemeter	y, cremetory or o	ther place)				1				
A dire	1 /	4 Donation 5 Other (Specify)	1top Service Corp. 4/3/93 Towson, Maryland 22. NAME AND ADDRESS OF FACILITY						ryland					
ALTI death. P funeral xamine	- 1	21. SIGNAL GIP CONTROL SERVICE LIG	//	11		22. N/	AME AN	D ADDRES		1050 1	7 - 201=	ר בת	1204	
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By the oval.		23. PART I. Enter the disesses, or c	and Heatless Abs		- 1	Ruc	k T	OWSOI	ı Fu	neral	Home	, Inc	•	
and and		shock, or heart fallure.	List only one ceu	ise on each	ie destn. Do r ilne.	ot enter ti	ne mod	de of dyle	ng, such	n as cerdia	or reapi	ratory arre	st,	Approximate interval Between
		IMMEDIATE CAUSE (Finel	4		-	_	,							Onset and Death
- 25 -		disease or condition resulting in death)	. AC	we	5	1001	bo							
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exect exect and to but	RTIFICATION	Sequentially list conditions,	DUE TO	(OR AS A CO	NSEQUENCE OF):									
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certificate ding physical principle	유	CAUSE (Disease or Injury	DUE TO	/OR 40 4 00	NOSOUS A									
Sein a die	Ē	that initiated events resulting in death) LAST	906 10	(OH AS A CO	NSEQUENCE DI	-):								1
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		PART II. Other significent condition	contribution to	donth hut a	net necesition 1	- 45	de Les							
H = [ - E	EDICAL	is other significant conditions	s contributing to	destin but i	not resulting i	n the und	erlying	ceuse g	iven in	Part I. 24	PERFORI			RE AUTOPSY FINDINGS AILABLE PRIOR TO
) = 2 = E	8 1									_  ,	YES 2		co	MPLETION OF CAUSE DEATH?
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L HE law requi	≥ 2									_				YES 2 NO
ATTENDING PHYSICIAN: The law requires CTOR: After this certificate has been signs a fart death with the State Dept. of Healt 28 is marked, or Item 23 shows in	SICIAN:	25. WAS CASE REFERRED TO MEDICAL					26 PH	ACE OF OT	ATH (O)	nt art.				
Y: The cate h	2	EXAMINER?	HOSPITAL:			OTHER:	20. PL	ALE UF OE	ATH (Che	ock only one)				
or Sertific	ΥS	1 TYES 2 THO	1 /inpatient 2	ER/Outpatie	nt 3 🗆 DOA	4 🗆 Nursin	ng Home	5 🗆 Res	idence	8 Other (S	(pecify)			
PHYSIC LINES CE WITH IT	PHY	27. MANNER OF DEATH	28a. OATE DF (Month, D	INJURY lay, Year)	28b. TIM	E OF 2	Sc. INJL WOF	JRY AT		28d. DESCR	IBE HOW IN	JURY OCCU	RED	
NG PHYS frer this ceath with	В	1 Natural 5 Pending 2 Accident Investigation			9.0	M	_	E\$ 2 🗌	NO					
NOING P T death Is man		3 Suicide 8 Could not be	28e. PLACE O	F INJURY —	At home, farm, s	treet, factor	y, office	1	$\neg$	26f. LOCATIO	ON (Street as	nd Number or	Rumi Route	Number
OR ATTENDING OR ATTENDING DIRECTOR: After hours after death item 28 is ma	ш ,	4 Homicide detarmined	building,	atc. (Specify)						City or 1	own, State)			
OR AT DIRECT Hours	COMPLET	so- occurren A A												
로 2 본 전 로 1	릴	(Check only	CIAN: To the best of	my knowledg	e, death occurre	d at the lim	e, dats	and place,	and dua	to the cause(	s) and mani	ner as stated	J.	
SPITA III 7	8 1	0/10) 2 MEDICAL EXAMINE	R: On the basis of e	xamination an	d/or investigatio	n, In my opi	nion, de	ath occure	d at the	time, data an	d place, and	due to the	cause(s) an	d manner as stated.
한 한 한 점	- 11	296. SIGNATURE AND TITLE OF CERTIFIER	-//											
TO THE HOSPI TO THE FUNER be filed within	#	HH/SI	lade					29c. LICEI			1	29d. DATE	SIGNED (Mo	onth, Day, Year)
TO THE HOSPITAL (TO THE FUNERAL DE FIED WITHIN 72 h	2	BIII CON	com					2	12	944		14-	- 4 -	73
4	- 1	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	SE OF DEATH	(ITEM 27) (Type,	Print)							11	93
(1)		MH-GHILAD	1,70	_ 76	100 8	254	E	RO	Dr	100	USOL	1,	101-1	81204
V		31. DATE FILED (Month, Day, Year)	La David	RIS SIGNATUL	5.02			9				, ,		
	- 1	APR 06 1993	rapid warias	Mary 10, 10										

1 - FOR STATE REGISTRAR	STATE OF MA		RTMENT OF HEA		AL HYGIENE REG. NO.		
1. DECEDENT'S NAME (First, MI	y York	GURNEY	YORK	2. DAT MON Y	E OF DEATH 4-	2-93 YEAR 93	TIME OF DEATH
4. SOCIAL SECURITY NUMBER 245 09 8424	1   KM 2   F	AGE (In yrs. lest birthday 75 YRS.		OURS MIN. 7. DAT	e of BIRTH - 19-19 17	Country)	ACE (State or Foreign
9a. FACILITY NAME (If not institute of the second of the s	ution, give street and number) Cott Key Medic	alCenter	96. CITY, TOWN OR I		90	COUNTY OF DEA	тн
RESIDENCE OF DECE							
Maryland	Balto Co	100	Sparrow P				Od. INSIDE CITY LIMITS?  YES 2 ND
100. STREET AND NUMBER 7221 Waln	ut Avenue		101. ZI	21219	10	g. CITIZEN OF WH USA	
11. MARITAL STATUS 1 Never Married 2 Ma 3 NWIdowed 4 Divorce	IF YES, GIVE WAL	YES 2 NO	If yes, specif	DENT OF HISPANIC ORIG y Cuben, Mexican, Puerto NO Specify:			- American Indian, White, etc. White
	ENT'S EDUCATION (ghest grade completed)  College (1-4 or 5+)		'S USUAL OCCUPATION If work done during most a use retired.)	f working	b. KIND OF BUSINES	ss/industry	
17. FATHER'S NAME (First, Middle	ie, Last)		16	L MOTHER'S NAME (First,	Middle, Maiden Sum	ame)	
19a. INFORMANT'S NAME (Type Mr Barnhill	C 1 PH 5		HG ADORESS (Street and I	Number or Rural Route Nur	nber, City or Town, Sti	ate, Zip Code)	
20e. METHOD OF DISPOSITION		20h PLACE AND DATE	E OF DISPOSITION (Name of other place)	ol OA	TE 20c. LOCATIO	ON — City or Town	), State
4   Donation 5   Other (Sc		novar					
Mul!	Ronal	d Wade, Di 4/5/93	r	Ltimore St,		Anatomy 21201	Board
23. PART i. Enter the dise ahock, or heel MMEDIATE CAUSE (Finel disease or condition resulting in death)	t fellure. List only one cause	caused the death. Do on each line.		of dying, such as ca	rdiac or respirato	гу агтеяt,	Approximate interval Between Onset and Death
Sequentielly list condition if any, leading to immedia cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Left low oue to co		ineumonic	dent			
PART II. Other significant	conditions contributing to de	eath but not resulting	g in the underlying co	euse given in Part i.	24a. WAS AN AUTO PERFORMED 1 YES 2	NO O	PERE AUTOPSY FINDINGS WAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?  YES 2 NO
25. WAS CASE REFERRED TO N EXAMINER?	HEDICAL HOSPITAL:		T	E OF OEATH (Check only o	one)		
1 TYES 2 NO		ER/Outpatient 3 DOA	OTHER: 4 Nursing Home	5 ☐ Residence 8 ☐ Ott	er (Specify)		
27. MANNER OF OEATH  1 Natural 5 Per 2 Accident	28e. DATE DF IN (Month, Day, estigation	IJURY 28b. Ti Year) II	IME OF 28c, INJURY WORKS	AT 28d. OI 2 ND	SCRIBE HOW INJUR	Y OCCUREO	
	uld not be 26a. PLACE OF building, et	INJURY — At home, farm c. (Specify)	, street, factory, office	281. LO	CATION (Street and A y or Town, State)	lumber or Rural Rou	rte Number,
enel .	TING PHYSICIAN: To the best of m L EXAMINER: On the beste of exam						nd manner as stated.
29b. SIGNATURE AND TITLE OF	Wonte W	D/atten	Anj 20	2485	29.	d. DATE SIGNED (A	forth, Day, Year)
30. NAME AND AGORESS OF PI	ERSON WHO COMPLETED CAUSE	OF DEATH (ITEM 27) (Typ	De, Printy	I. Maria	0.100	1+	

TO BE COMPLETED BY FUNERAL DIRECTOR

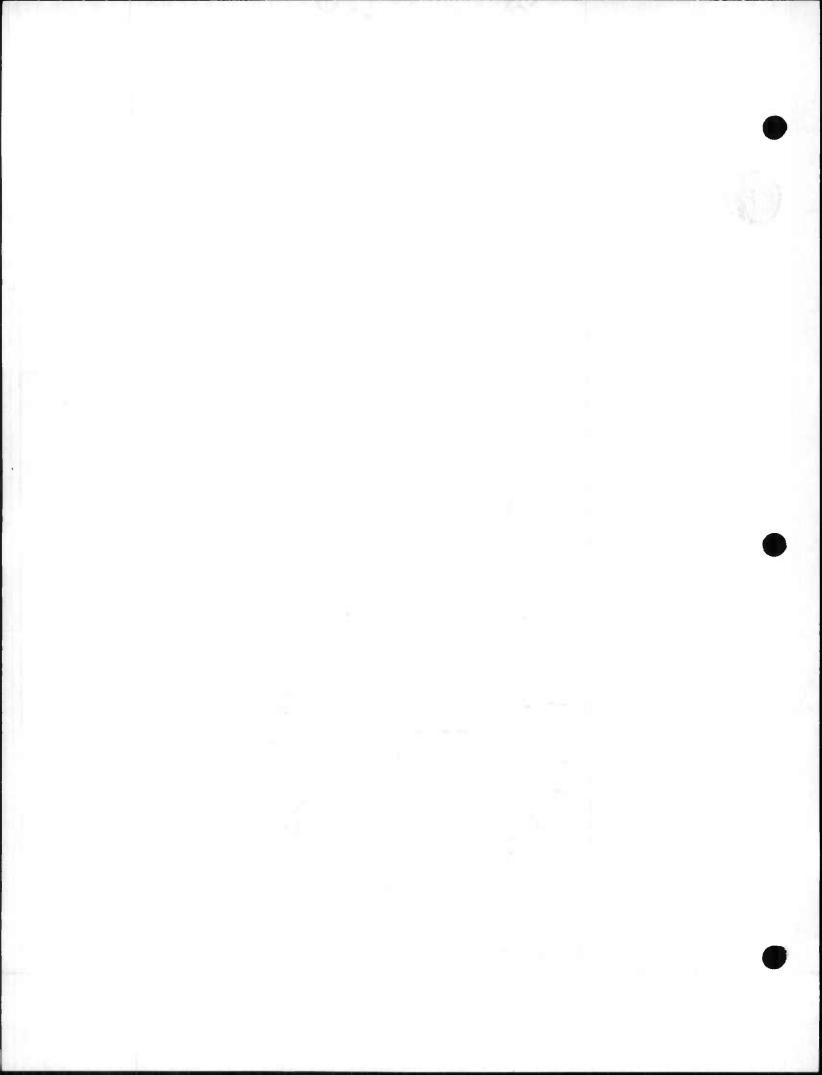
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

31. DATE FILED (Month, Day, Year)

0 7 1993

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be rotained by the hospital or attending physician.



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DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit, Pages 1, 2, 3 should	hours after death with the State Dept, of Health and Mental Hygiene prior to burlal, cremation, or removal.	Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
D THE HOSPITAL OR ATTENDING PHYSIC	TO THE FUNERAL DIRECTOR: After this	be filed within 72 hours after death with th	IPORTANT: If Item 28 is marked,
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1. DECEDENT'S NAME (First, Middle, Last)  Bernard L. Zell					MON	ch 30,	1002	YEAR	3. TIME OF DEA	rh P
	5. SEX 6. A	GE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH	1993	6. BIRTHP	LACE (State or F	
579-40-6417 9a. FACILITY NAME (If not institution, give stre	1 M 2 F	63 YRS.	9b. CITY. TOWN	HOURS MIN.	2/3	th, Day, Year) 3/30	ac com	Country)	ington	
8602 Cunningham D RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Maryland Prince	)rive			Heights					orge's	
10a. STATE 10b. COUNTY	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION									,
	George's	Berw	yn Heigh						1 YES 2	NO
A THE RESIDENCE OF THE PARTY OF	) witto			1, ZIP CODE 20740			1		AT COUNTRY?	
8602 Cunningham D		R IN U.S. ARMED		ENDENT OF HISPA	NIC OBIG	N2 (Specify Vee		ed St	- American Indi	-
3 Widowed 4 Divorced	12. WAS DECEDENT EYE FORCES? XXXXV IF YES, GIVE WAR OF 1951-1954	ES 2 NO R DATES	If yes, sp	ecity Cuben, Mexic 2 X NO Spec	en, Puerto	Rican, etc.)	J. 110-	Specify	White, etc.	m+1,
15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)  17. FATHER'S NAME (First, Middle, Last)		16e. DECEDENT'S (Give kind of w life. Do NOT us	vork done during me	ON ost of working	16	b, KIND OF BUS	SINESS/IND			
		Station	ary Engi	lneer	]	labor n	ewsp	aper		
				18. MOTHER'S N			Sumeme)			
Francis Courtland	1			Nancy :						
Dolores Zell		- 1		nd Number or Rurel					20740	
20a METHOD OF DISPOSITION  L'EXBurial 2 Cremation 3 Remov	val from State	20b. PLACE AND DATE Of cemetery, crematory or otion	F DISPOSITION (Na	ame of	DAT	TE 20c. LO		City or Tow		
4 Donation 6 Other (Specify)	No.	cernetery, cremetory or of ort Linco							ryland	
1/02/8. A	<i>(</i> ).	M00877	Fort I	no adoress of F Lincoln Bladensb	Fune: urg F	cal Hom Road, B	ne, I	nc. wood,	Md 20	722
shock, or heart fellure. Li iMMEDIATE CAUSE (Finei disease or condition									Interval B	
resulting in death)  a.  Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	Glioblas DUE TO (OR A	Imonary Ar s a consequence of toma Multi s a consequence of	forms						Onset and	i Deat
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BALTIMORE, MARYLAND 21203-3146

FOR STATE REGISTRAR

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2 7	PHYSICIAN:
DIVISION OF VITAL RECORDS, P.O. BOA 13140	TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within
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	HOSPITAL
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	j	1. DECEDENT'S NAME (First, Middle, Last	)		141					2. DATE MONT	OF DEATH		YEAR	3. TIME OF DEATH
- 1		Walter Albert	Jr.							4/6/93				5:50 AM
- 1		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.	last birthday)	AF UNDE	R 1 YEAR	IF UNDER	24 HRS.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTH Countr	IPLACE (State or Foreign
_	ì	215-05-6817	1 □XM 2 □ F	82	YRS.	MONTHS	DATS	HOURS	mire,		3/10			Baltimore
3 should		9a. FACILITY NAME (If not institution, give street and number)					9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH					EATH		
1, 2, 3	DIRECTOR	Maryland Masonic Homes					Cockeysville				Baltimore			
Sedi	Ä	10a. STATE 10b. COUN					OR LOCAT					_		10d. INSIDE CITY LIMITS?
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Tied .	FUNERAL	10e. STREET AND NUMBER					101	. ZIP COD	E			10g. CITI		WHAT COUNTRY?
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the burial-tr	BY	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	NT EVER IN U.S. 1 YES 2 ( WAR OR DATES	ARMED Mo	13.	Il yes, sp		ın, Mexica	n, Puerto	t? (Specify Yes Ricen, etc.)	or No-	14. RACE — American Indian, Black, White, atc. Specify: White		
e as	ETED.	15. DECEDENT'S EC		16a.	DECEDENT'S	USUAL	OCCUPATION	ON		16b	. KIND OF BUS	SINESS/IND	USTRY	
or us		(Specify only highest gra Elementary/Secondary (0-12)	College (1-4 or 5	+)	(Give kind of life. Do NOT u	se retired.	)	at or work	ng					
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detach once.	COMPL	17. FATHER'S NAME (First, Middle, Lest)						16. MOT	HER'S NA	ME (First,	Middle, Malden	Surname)		
d be	BE (	Walter Albert	Sr.							I	illie	Stur	geor	)
5 should notified	2	19a, INFORMANT'S NAME (Type/Print)									ber, City or Tow			
be no	F	H. Marvin Wh	ittle		610 N	Bou	ldi	n St	ree	t ]				D 21205
r, pa		20a. METHOD OF DISPOSITION 1 N Burlel 2 Cremation 3 Re	moval from State	othe	CE OF DISPO							CATION -		
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etely filled in by the emation, or removent, the medical		shock, or heart failule. List only one cause on each fina.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  a. Neumon t a										Approximate interval Between Onset and Death		
signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, Heatth and Mental Hygiene prior to burial, cremation, or removal.  was any injury, or other traumatic event, the medical examiner must be notified at once.	CERTIFICATION	Sequentially list conditions, if any, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST												
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peen signed by the att of Health and Menta shows any injury,	MEDICAL	VAIL II. OHA SIGNION COLOR	<u> </u>	0040100111							PERFOI	RMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
certificate has been the State Dept. of 1, or Item 23 sho	CIAN:													
State D	ਤੇ	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			отни		LACE OF I	DEATH (C/	eck only o	ne)			
he St	HYSI	1 TYES 2 NO	1 Inpatient 2			4 & N	ursing Hor		lesidence		er (Specify)			
th with tarked,	> A	27. MANNER OF DEATH  1 Natural 6 Pending 2 Applicant Investigatio		Day, Year)	26b. TH	ME OF JURY M	W	JURY AT DRK? YES 2	□ NO	28d, DE	SCRIBE HOW	INJURY OC	CURED	
FUNERAL DIRECTOR: After this o within 72 hours after death with ITANT: If Item 28 is marked,	TED B	2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide determined  28e. PLACE OF INJURY — Al home, farm, street, factory, office building, etc. (Specify)  28l. LOCATION (Street and Number or Rural Route Number, City or Town, State)								Route Number,				
DIRE	,E	29a. CERTIFIER 1 CERTIFYING PH	/SICIAN: To the best	of my knowledge	, death occur	red at the	Ilme, date	and plac	e, and du	to the ca	use(a) and me	nner as sta	ted.	
RAL 72	COMPI	One)    CERTIFYING   Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(a) and menner as stated.    One									a) and menner as stated.			
Withi		29b. SIGNATURE AND TITLE OF CERTIF	TER.					29c. Life	ENSE NU	MBER		29d. DAT	E SIGNE	D (Month, Day, Year)
TO THE FUNERA be filed within 7 IMPORTANT:	BE	Gohn W.	Bow	ie 7	10				20		9	1	1/6	193
2 8 €	욘	30, NAME AND ADDRESS OF PERSON	WHO COMPLETED CA	USE OF DEATH	(ITEM 27) (Typ	e, Print)			-				· · - /	, -

6800 York Road

32. REGISTRAR'S SIGNATURE

Baltimore, MD 21212

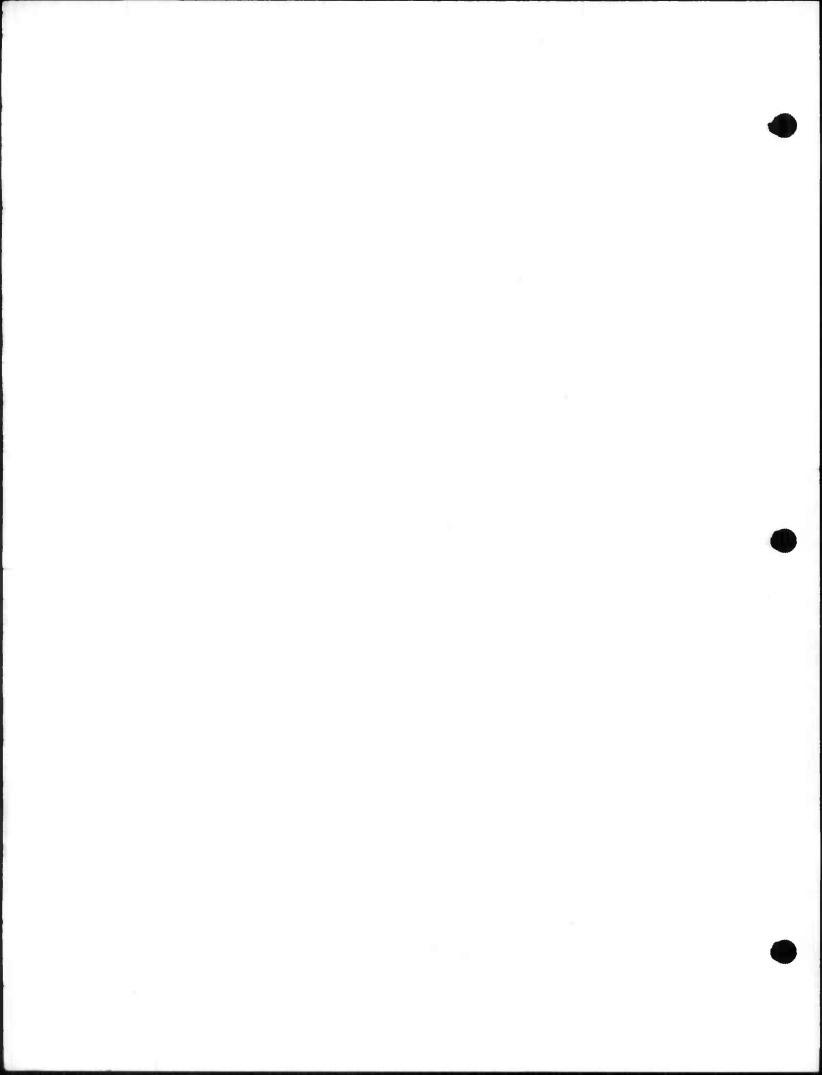
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** 

93 09867

John Bowie M.D.

31. DATE FILED (Month, Day, Year)

APR 08 1993



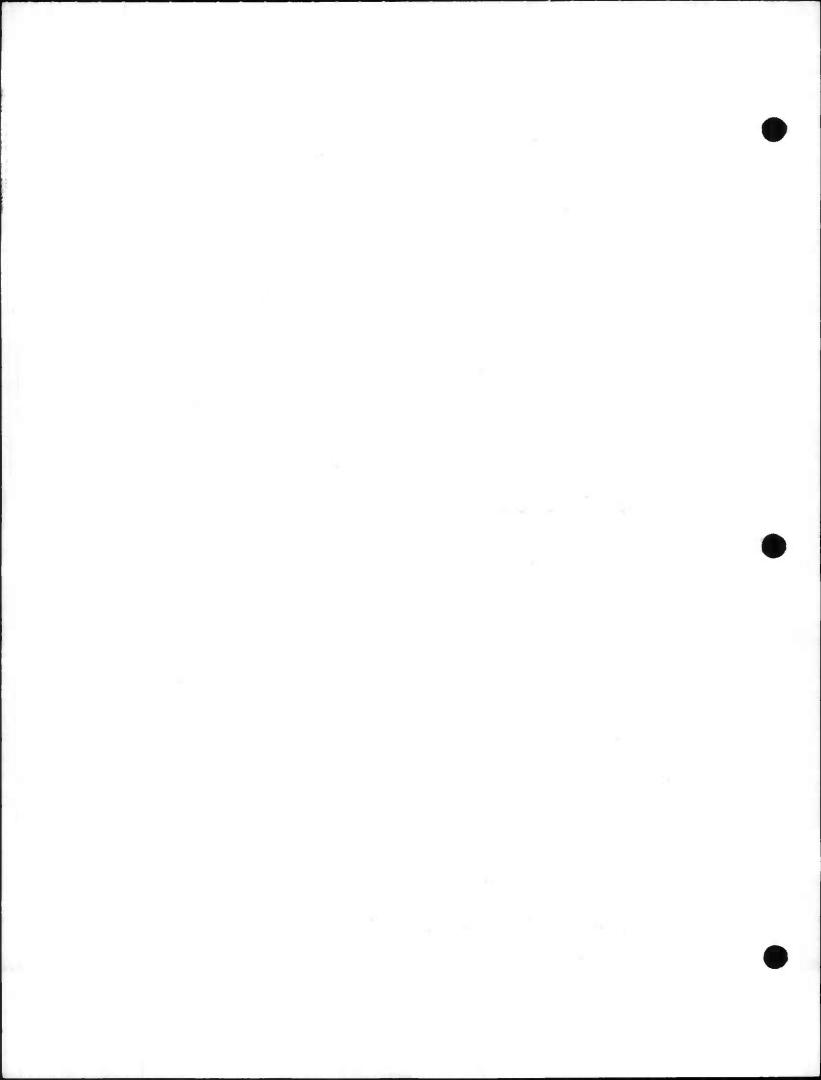
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	TO THE HOSPITAL OR ATTENDING PRINCED IN PAGE 10 IN THE New requires that the death certificate be executed within 24 hours after death. Page 6 may be retained for the hours after death.	TO THE HOSPITAL OR ATTENDING PINNELS of the law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained to THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 shou	TO THE HOSPITAL OR ATTENDING PHYSILEM. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained to THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 shout be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

1 . S	OR TATE EGISTRAR	STATE OF MARY	LAND / DEPART CERTIFI	MENT OF HEALTH AN	D MENTAL HYGIEI		3 0986
1, DEC	EDENT'S NAME (First, Middle, Last) HAMDA		MUTAIRAN	ALENEZI	2. DATE OF DEATH MONTH 7,	19 <b>9</b> 3	3. TIME OF DEATH
4. 900	HAL SECURITY NUMBER	5. SEX 6. AG	9 YRS.	IF UNDER 1 YEAR IF UNDER 24 H MONTHS DAYS HOURS MI	Miles No. Mari	- 1	BIRTHPLACE (State or For Country)  WAIT
	THE JOHNS HOP	· ·		96. CITY, TOWN OR LOCATION OF BALTIMORE (		9c. COUNTY BAL	OF DEATH TIMORE CITY
PEST 10e. ST		WAIT	10c. CITY,	TOWN OR LOCATION			10d. INSIDE CITY LIMITS?
10e. ST	REET AND NUMBER HOUSE ! #299	St. # 4		101, ZIP CODE	. <u>.</u>	10g. CITIZEN	OF WHAT COUNTRY?
11. MAI	RITAL STATUS lever Married 2 Married Vidowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 VE IF YES, GIVE WAR OR	S 2 100	13. WAS DECENDENT OF HI If yes, specify Cuben, M 1 YES 2 NO S	exican, Puerto Rican, etc.)		RACE — American India Black, White, atc. Specify: WAITIAN
MPLETED	15. DECEDENT'S EDI (Specify only highest grad mentary/Secondary (0-12)		16a. DECEDENT'S U (Give kind of wo like. Do NOT use Stude	ork done during most of working retired.)	16b. KIND OF BI	USINESS/INDUS	
0 17. FAT		Alenezi		18. MOTHER	B NAME (First, Middle, Maide	n Sumeme)	
19a, IN	FORMANT'S NAME (Type/Print) Hussian Alen	ezi		ADDRESS (Street end Number or R		wn, Stata, Zip Co ait	de)
1 € Be 4 □ D	ETHOD OF DISPOSITION urlal 2 Cremation 3 Remonstron 5 Other (Specify)	noval from State	tob. PLACE AND DATE OF commetery, cremetery or oth Fam C	er place)		ocation - city  Kwait	
21. SIG	Wellian	C. Mo	nel	March F/H		01 E.	North Av
NO Seque if any cause CAUS that is	entially list conditions, leading to immediate. Enter UNDERLYING E (Disease or injury nitiated events ing in death) LAST	b. ARDS DUE TO (OR AS	S A CONSEQUENCE OF)  S A CONSEQUENCE OF)	sofficialies	arrew trans	splantai	18 da
MEDICAL	H. Other algoriticent condition	ne contributing to death	but not resulting in		PERFO	N AUTOPSY DRMED? 2 NO	24b. WERE AUTOPSY FR MAILABLE PRIOR 1 COMPLETION OF CO OF DEATH? 1 YES 2 N
O EX	S CASE REFERRED TO MEDICAL AMINER? YES 2 NO	HOSPITAL:		26. PLACE OF DEATH OTHER: 4  Nursing Home 5  Reside	20 10		
H 27. MAI	NNER OF DEATH   Neture  5   Pending investigation	260. DATE OF INJUR (Month, Day, War	Y 28b. TIME	OF 28c. INJURY AT	28d. DESCRIBE HOW	INJURY OCCUR	ED
ETED	Suicide 6 Could not be determined	26e. PLACE OF INJUI building, etc. (S)	RY — At home, farm, str	reet, factory, office	281. LOCATION (Street City or Town, State	and Number or I	Rural Route Number,
				et the time, date end piece, and , in my opinion, death occured a			suse(e) and manner as st
29b. Sid	CHATUBETIND TITLE OF CERTIFIE	Das	Chy c	29c. LICENSE	NUMBER 43054	29d. DATE SI	GNED (Morith, Day, Year)
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		FOR 1 - STATE	STATE OF MARYL				MENTAL HYGIENE	93 09069
		REGISTRAR  1. DECEDENT'S NAME (First, Middle, Last)	· + 1	CERTIF	ICATE OF	DEATH	REG. NO.  2. DATE OF DEATH MONTH DAY	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	03 3   7. DATE OF BIRTH	8. BIRTHPLACE (State or Foreign
모			1 🗆 M 2 💢 F	76 YRS.	MONTHS DAYS	HOURS MIN.	(Morith, Day, Year) 1-10-1917	VIRGINIA
3 should	œ	9a. FACILITY NAME (If not institution, give s	street and number)		9b. CITY, TOWN	OR LOCATION OF E	DEATH 9c.	COUNTY OF DEATH
1. 2.	CTO	HARBOR HOSPITAL RESIDENCE OF DECEDENT 104. STATE 104. COUNT			BALTI			
Pages	DIRE	10a. STATE 10b. COUNT	Y	10c. CI	CLIEDD		an a	10d. INSIDE CITY LIMITS?
permit.	ERAL	10e. STREET AND NUMBER	·			YHILL, M		1 → YES 2 → NO J. CITIZEN OF WHAT COUNTRY?
physician. burial-transit	NER	425 ROUNDVIEW ROA				21225		USA.
	BY FUN	1 Never Married 2 Married 3 Never Married 2 Divorced	12. WAS DECEDENT EVER II FORCES? 1 1 YES IF YES, GIVE WAR OR D	3/XNO	If yes, sp	ENDENT OF HISPA ecity Cuben, Mexic 2 XNO Spec	ANIC ORIGIN? (Specify Yes or No an, Puerto Rican, etc.) #y:	o- 14. RACE - American Indum. Blacky White, atc. BLACK
or atter	ETED.	15. DECEDENT'S EDU (Specify only highest grade	completed)	16a. DECEDENT'S (Give kind of life. Do NOT u	Work done during mo	ON ist of working	16b. KIND OF BUSINES	S/INDUSTRY
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the hospit detached		17. FATHER'S NAME (First, Middle, Last)					AME (First, Middle, Meiden Surna	ime)
5 should be notified at		JAMES  19a. INFORMANT'S NAME (Type/Print)	MOOD	19b. MAILING	ADDRESS (Street a		WILLIAMS  Route Number, City or Town, Stell	to The Codes
	2	SAM WOOD			WALTERS		, say at 1000, state	10, 25 0000)
e 6 may be ector, page must be		20a METHOD OF DISPOSITION 1 \( \times \) Burlet 2 \( \times \) Cremetion 3 \( \times \) Rem 4 \( \times \) Donation \( \frac{5}{2} \) Other (Specify)			OF DISPOSITION (Na Other Diace) NAL CEME			DN — City or Town, State
Page	1	21. SIGNATURE OF FUNERAL SERVICE LI		J. NATIO	22. NAME AI	NO ADDRESS OF F	ACILITY	L, MARYLAND
41 40	21.7	- Usan	10	$\sim$			WN JR. FUNERA RE ST. BALTO. MD	AL HOME, P.A. . 21223; P.O. BOX 4433
E 3 2		23. PART I. Enter the disesses, or ahock, or haart failure.	complications that cause List only one cause on a	d the daath. Do ach lina.	not entar tha mo	da of dying, su	ch aa cardiac or reapiretor	y arrest, Approximata
ted within 24 hours completely filled in t ial. cremation. or rei		IMMEDIATE CAUSE (Finsi disease or condition resulting in death)	. Adeno	CA	of the	· R	ore eunonia	Onset and Death
and com bunial.	NO	Sequentially list conditions,	b. Rospo	CONSEQUENCE	my !	Tails	ore	
sician prior t	ICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	. Polin	· EH	win	pr	emonia	Inots:
ding tygie	ERTIFIC	that initiated events resulting in death) LAST	OUE TO (OR AS A	CONSEQUÊNCE O	F):		/	
atte atte	0	PART II. Other significant condition	s contributing to death h	aut not resulting	in the underlying	a course alves la	Boot I Late was an augus	
that ed b	DICAL			at not readiting	THE GIGGETYNI	g cause given ii	Part I. 24a. WAS AN AUTO PERFORMED?	? AMAILABLE PRIOR TO COMPLETION OF CAUSE
law requires as been sign lept. of Healt 23 shows	M							OF DEATH?
The law ste has be ate Dept.	IAN:	25. WAS CASE REFERRED TO MEDICAL			26, PL	ACE OF DEATH (C	heck only one)	
SICIAN: The lan certificate has n the State Dep 1, or Item 23	YSICI	EXAMINER?	HOSPITAL:	petient 3 DOA	OTHER:		8 Other (Specify)	
PHY this with	ву Рн	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28e. OATE OF INJURY (Month, Day, Year)	28b. TM	JURY WO	URY AT RK? (ES 2 NO	28d. OEŞCRIBE HOW INJURY	Y OCCUREO
TTENDI TOR: A after d	ETED 8	3 Suicide 6 Could not be 4 Homicide determined	28a. PLACE OF INJURY building, atc. (Spec	Al home, ferm,	streel, factory, office		281. LOCATION (Street and Nu City or Town, State) HHC 3001 S	umber or Rural Route Number,  Housever Street
Z ZZ =	COMPLI						a to the cause(a) and manner as	a stated. to the cause(a) and menner as stated.
TO THE HOSPI' TO THE FUNER DE filed within IMPORTANT:	BE	29b. SIGNATURE AND TITLE OF CERTIFIE	Dull	- nuj	D.	29c. LICENSE NU	MBER 29d.	DATE SIGNEO (Month, pay, Year)
	10	30. NAME AND ADDRESS OF PERSON WH	O BOMPLETED DAUSE OF DE	ATH (ITEM 27) (Type		C. Ha.	rover str	Baltimore
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE	8001	3 11-4	2000	
		APR 08 1993	Julia Davidson	. Aandell				



THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Fours after death. Page 6 may be retained by the hospital or attending the companies that the death certificate be executed within Fours after death. Page 6 may be retained by the hospital or attending the companies that the death certificate be executed within Fours after death.
THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the best harmst permit. Pages 1, 2, 3 should within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

L	SIMON DH.	BIZZE	LE	MONTHPRIL DAY 4	YEAR 3. TIME OF DEARH
3	0. A 2 0 F	The state of the s	UNDER 1 YEAR SF UNDER 24 HRS.  HOURS MIN.	Month, Day, Year) 2-11-26	a. BIRTHPLACE (State or Foreign Country)  N • C •
5	FACILITY NAME (If not institution, give street and number) T. AGNES HOSPITAL	96	BALTIMORE	TH 9c, COUI	NTY OF OEATH
	A. STATE 10b. COUNTY		DWN OR LOCATION LTIMORE	-	10d. INSIDE CITY LIMITS? 1 XXES 2 \( \text{NO}\) NO
1	STREET AND NUMBER 2565 W. LOMBARD STREET		101. ZIP CODE 21223		J.S.A.
15	MARITAL STATUS    Merried   12   Married   12   WAS DECEDENT EVIFORCES?   1   1   1   1   1   1   1   1   1		13. WAS DECENDENT OF HISPANIC If yee, specify Cuban, Mexican, 1 YES 2 NO Specify:		14. RACE — American Indian, Black, White, atc. Specify: BLACK
F	15. OECEOENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  9th  Coffege (1-4 or 5+)	16e. DECEDENT'S USE (Give kind of work life. Do NOT use re DISABL	done during most of working tired.)	16b. KIND OF BUSINESS/INC	DUSTRY
3	FATHER'S NAME (First, Middle, Last) SIMON BIZZELLE		LILL	(First, Middle, Malden Surname) E DANIEL	
	a. INFORMANT'S NAME (Type/Print)  CATHERINE BIZZELLE		DRESS (Street and Number or Rural Ro LOMBARD ST		
12	e. METHOD OF DISPOSITION   Burlel   2	other place)	ON (Name of cemetary, crematory or  N CEMETERY  22. NAME AND ADDRESS OF FACE	BALTIM	City or Town, State  1ORE, MD
1	Manena Lat		WM.C.MARCH F		NORTH AVE.
Sifico	equentially list conditions, any, leading to immediate susse. Enter UNDERLYING	AS A CONSEQUENCE OF):  AS A CONSEQUENCE OF):	e Heart dis mys p iv = Avil	- Parlin Patty	2 uzsit
P	ART II. Other algrificant conditions contributing to dea	th but not resulting in :	he underlying cause given in P	PERFORMED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2 NO
25	WAS CASE REFERRED TO MEDICAL EXAMINER?  1   YES 2   NO   1   Inpetient 2   ER		26. PLACE OF DEATH (Chec THER:		
27	MANNER OF DEATH  1 Netural 5 Pending (Month, Day, Ye 2 Accident Investigation	JRY 28b. TIME O INJURY	F 28c. INJURY AT WORK? M 1 YES 2 NO	28d. DESCRIBE HOW INJURY OC	
L	8 Could not be building, etc.	JURY — At home, ferm, stre- (Specify)	et, tectory, office	281. LOCATION (Street and Number City or Town, State)	r or Rural Route Number,
25	e. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of my to the best of axeminate the best of axeminate the basis of axem				
29	SIGNATURE AND TITLE OF CERTIFIER	fin !	29c. LICENSE NUME	ER 29d. DAT	TE SIGNED (Monty Day, Mar)
1	NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE O	Gay 7.A	Cs: 300	Secom Ba	17 ml 2122
1	APR - 8 1993 Fishia David	SIGNATURE Sur-Adaptable			

use as the burial-transit permit. Pages 1, 2, 3 should

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the attending physician and con Mental Hygiene prior to burial,

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31. DATE FILED (Month, Day, Year)

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	SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 30 Doris May Buckheit 4 SOCIAL SECURITY NUMBER 5 SEY 8. AGE (In yrs. lest birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH B. BIRTHPLACE (State or Foreign NOV. 24 220-14-8955 1 M 2 X F Maryland 1925 Sa. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH CENTER MERQV DIRECTOR men Baltimore RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Maryland Baltimore 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3867 Lyndale Ave. 21213 S. A. U. 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexican, Puerto Rican, etc.)

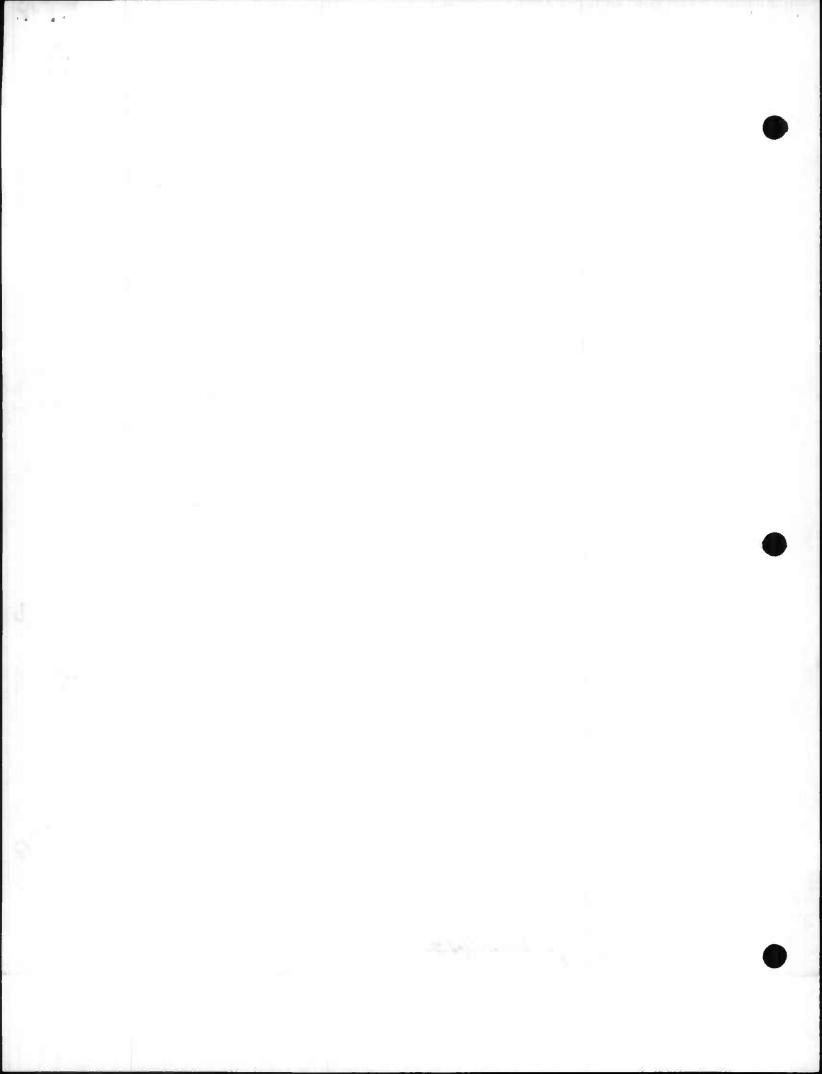
1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 14. RACE — American Indian, Black, Whits, etc. 1 Never Married 2 Married IF YES. GIVE WAR OR DATES BY 3 Widowed 4 Divorced Specify: White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY dary (0-12) College (1-4 or 5+) NA Homemaker NA Own Home 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Sumame) Morris Ira Decker Martha Triplett notified at BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 9 Leonard M. Buckheit Jr. (Son) 107 Alison Rd. Apt. F-23, Horsham, Pa. 19044 9 29a. METHOD OF DISPOSITION

t

Burlel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must competery, geneatory or other place)

Carrottery

Of Faith Cemetery 4/2 Baltimore, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY examiner Schimunek Funeral Home 3331 Brehms Lane, Baltimore, Md. ed in by the t 21213 medical 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feliure. List only one cause on each line. Approximata interval Between **IMMEDIATE CAUSE (Fine)** Onset and Death the disease or condition PULMONARY event. resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): traumatic PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, if any, leading to immediate TASTATIC
DUE TO (OR AS A CONSEQUÊNCE OF) cause. Enter UNDERLYING CAUSE (Disease or Injury or other that initiated events resulting in death) LAST shows any injury, PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE YES 2 | NO 1 TES 2 NO been . State Dept. ( 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate the State I EXAMINER? HOSPITAL: OTHER: Inpetient 2 - ER/Outpetient 3 - DOA me 5 🗀 Residence 6 🗀 Other (Specify) 5 27. MANNER OF DEATH 26s. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 286. TIME OF 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural
2 Accident 5 Pending 1 YES 2 NO BY DIRECTOR: Att hours after de: Item 28 Is n 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide e FUNERAL DIN.
vithin 72 hours.
VT. If Item 28 29s. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated, IMPORTANT: 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 01548 2 2 3 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)



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LOR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death. Page 6 may be reta	. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 sl	
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is marked, or item 23 shows any injury, or other traumatic event, the medical examiner

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93 09872 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH BESSLING CHARLES 0 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. B. BIRTHPLACE (State or Foreign 1 4 M 2 - F 215-12-1258 29-9a. FACILITY NAME (If not institution, give street and number) 9c. COUNTY OF DEATH FUNERAL DIRECTOR Baltimore County Gen'l Hospita Baltimore Randallstown 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Md Baltimore 1 YES 2 NO Owings Mills 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Hartley Cir -Owings Mills S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No. If yes, specify Cuben, Mexican, Puerto Rican, etc.)
 U YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. FORCES? 1X YES 2
IF YES, GIVE WAR OR DATES 2 NO 1 Never Married 2 Married BY Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+1 N/A N/ etired Service Stati on Owner-Self Employed 17. FATHER'S NAME (First Middle Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruby Bessling Margaret Johnson 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bessling Hartlev Mills -Owings Md 20s. METHOD OF DISPOSITION
1 Burlal 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE Md. Cemetery Haven 1993 Glen Apr Burnie 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 5151 Baltimore National Pike Truman Schwab Baltimore. Md 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between **IMMEDIATE CAUSE (Final** Onset and Death sechelele disease or condition Myocardia perfecte resulting in death) DUE TO (OR AS A CONSEDUENCE OF Sequentially list conditions, DUE TO (DR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEDUENCE OF): that initiated events resulting in desth) LAST PART ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMED? 1 NES 2 NO OF DEATH? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26, PLACE OF OEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 YES 2 NO e 5 🗆 Residence 6 🗆 Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 A Natural 5 Pending Investigation 1 YES 2 NO 2 Accident 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be

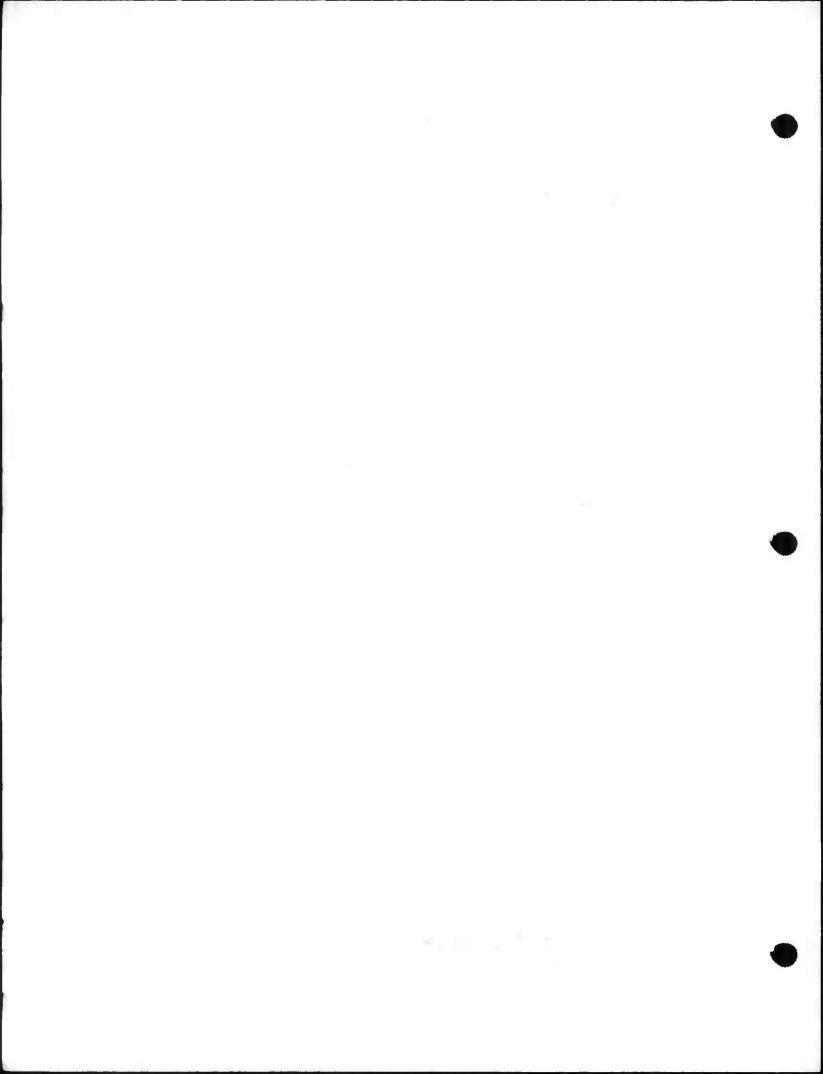
2 PHYSICIAN: MEDICAL CERTIFICATION BY 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) COMPLETED 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. BE 29d. DATE SIGNED (Month, Day, Year) 1120806 61 2 AND ADORESS OF PERSON WHD COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print) ATRICK URNES 32. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146	TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 yours after death. Page 6 may be retained by the hospital or attending physician.	; certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 1314	AL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the to the fled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	If Item 28 is marked, or item 23 shows any injury, or other traumatic er
	TO THE HOSPI	TO THE FUNEF be filed within	IMPORTANT

31. DATE FILED (Moreth, Day, Year)

APR 08 1993

	1 - FOR STATE REGISTRAR	TATE OF MARYLAN	D / DEPARTME CERTIFICA			ENTAL HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Lest)  Jeffrey Tyl	er BROOKS	12.			DATE OF DEATH MONTH DA	γ νε	3. TIME OF DEATH  3.43 DINO M
	4. SOCIAL SECURITY NUMBER 5. S	SEX 6. AGE (In y				7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign
	Intant	<b>X</b> M 2 □ F	YRS. MONT	14	6 55	4/5/983	N	(Country)
<b> </b>	9e. FACILITY NAME (If not institution, give street a				LOCATION OF DEAT	LH ,	9c. COUNTY	
57	Franklin Square Hos	pital Center	r	Rossvi	146		Balti	Imore
DIRECTOR	10e. STATE 10b. COUNTY Baltimor	·e	100	e Rive				10d. INSIDE CITY LIMITS? 1 □ YES 2 ☑ NO
\¥L	10e. STREET AND NUMBER				IP CODE			OF WHAT COUNTRY?
FUNERAL	31 Beech Drive				1220		U.S.	
BY FU	11. MARITAL STATUS  1 Never Married 2 Married  3 Widowed 4 Divorced	WAS DECEDENT EVER IN U. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATE	P NO	If yes, speci	fy Cuben, Mexican,	ORIGIN? (Specify Yes Puerto Rican, etc.)		RACE — American Indian, Black, White, etc. Specify: Vhite
Ë	15. DECEDENT'S EDUCATION (Specify only highest grade company)	DN 16	e. DECEDENT'S USUA	L OCCUPATION	of working	18b. KIND OF BUS	INESS/INDUST	rry
COMPLETED	Elementary/Secondary (0-12) Co	offege (1-4 or 5+)	(Give kind of work d life. Do NOT use retir	ed.)	or worning			
₩		ifant :	infant			infant		
BE CO	17. FATHER'S NAME (First, Middle, Lest) Shawn Jeffrey Broo	ks			Robin I	E (First, Middle, Meiden Lynn Ferg	guson	
2	19a. INFORMANT'S NAME (Type/Print)  Mr. Shawn J. Brook	46			Number or Rural Ro	ute Number, City or Town	n, State, Zip Coo	de)
	20s. METHOD OF DISPOSITION		Same a		ery, crematory or	20c. LO	CATION — City	or Town, State
	1XXBurtel 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	from State of	her place)	Lawn Ce			timore	
	21, SIGNATURE OF FUNERAL SERVICE LICENS	E Paul L. Hart			AODRESS OF FACI			
	+ Kenl L Hart	and Do	no control de la control de la control de la control de la control de la control de la control de la control de	Leonar	d J Ruc	k,Inc. 5	305 Ha	rford Pd
	23. PART i. Enter the diseases, or com- ahock, or heert fellure. List	plications that caused th	e death. Do not e					
	IMMEDIATE CAUSE (Finel	Only time cause on each	i illie.					Onset and Death
	disease or condition resulting in death)	Extreme imma		22 Wee	k gestat	ion fetus	3	
2		DOE TO (OH AS A CO	MSEQUENCE OF):					
CERTIFICATION	Sequentielly list conditions, If any, leading to immediate	DUE TO (OR AS A CO	ONSEQUENCE OF):					
S	cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS A CO	DISEOTIENCE OF:					
RTIF	that initiated events resulting in death) LAST	DUE TO (ON AS A CO	MSEQUENCE OF).					
핑	d							
CAL	respiratory distres							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDI	rubinemia, patent d					1 🗆 YES 2	MO MO	OF DEATH?
	cranial hemorrhage.		10343, 01	uuc IV	211010	_		1 TYES 2 NO
SICIAN:	25. WAS CASE REFERRED TO MEDICAL				CE OF DEATH (Chec	k only one)		
SIC		OSPITAL: Inpatient 2 - ER/Outpatie		HER: Nursing Home	5 - Residence 6	Other (Specify)		
ВУ РНУ	27. MANNER OF DEATH  1 X Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c, INJUI WOR		28d. DEŞCRIBE HOW I	NJURY OCCUR	BED
8	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY — building, etc. (Specify)		, factory, office		261. LOCATION (Street of City or Town, State)		Rural Route Number,
COMPLET	CONDUM OTHY	N: To the best of my knowled						couse(s) and manner as stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIER	lesto	16		29c. LICENSE NUME	- 1	29d. DATE S	IGNED (Month, Day, Year)
2	30, NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEAT	H (ITEM 27) (Type, Print	1)	0 -(20			V//.5
-	30. NAME AND ADDRESS OF PERSON MITO CA							



YEAR

3. TIME OF DEATH

10d. INSIDE CITY

8. BIRTHPLACE (State or Foreign

Baltimore

3:42AM

IORE, MARYLAND	
BALTIN	
68760,	
BOX	
P.O.	

FOR STATE REGISTRAR

1 -

1. DECEDENT'S NAME (First, Middle, Last)

Joseph Paul Benedetta 2. DATE OF DEATH DAY April 4,1993 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER t YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 1 M 2 F 215-44-0002 5/26/194 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It liem 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH FUNERAL DIRECTOR General Hospital Falston RESIDENCE OF Falston Harford 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MD Harford Edgewood 100. STREET AND NUMBER 10f. ZIP CODE 1905 Eloise Lane 21040 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: D 21215-0020 FORCES? 1 VES 2
IF YES, GIVE WAR OR DATES 2 NO 1 Never Married 2 Married ВҰ 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+) €<sub>arpt</sub> Carpenter 12 Years Years 17. FATHER'S NAME (First, Middle, Last) ts. MOTHER'S NAME (First, Middle, Maiden Surname) Isadore Benedetta BE Mary Carpella 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 1905 Eloise Lane Baltimore MD 21040 Frank Benedetta 20e. METHOD OF DISPOSITION

1 Burial 2 Cremation 3 Red
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Dulaney Valley Mem Gardens 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 7 NAME AND ADDRESS OF FACILITY Dippel Funeral HOme Baltimore MD 21206 23. PART I/Enter the diseases, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. IMMEDIATE CAUSE (Final VEUTROPENIC disease or condition SEPSIS resulting in death) PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST DIVISION OF VITAL RECORDS, PART II. Other significant conditions contributing to death but not seaulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO CORONAR SEASE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 Impetient 2 ER/Outpetient 3 DOA OTHER: 1 YES 2 10 4 - Nursing Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation BY 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide COMPLETED 6 Could not be 4 Homicide 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. tion and/or investigation, in my opinion, death occured at the time, date and place, and BE 29c. LICENSE NUMBER 2

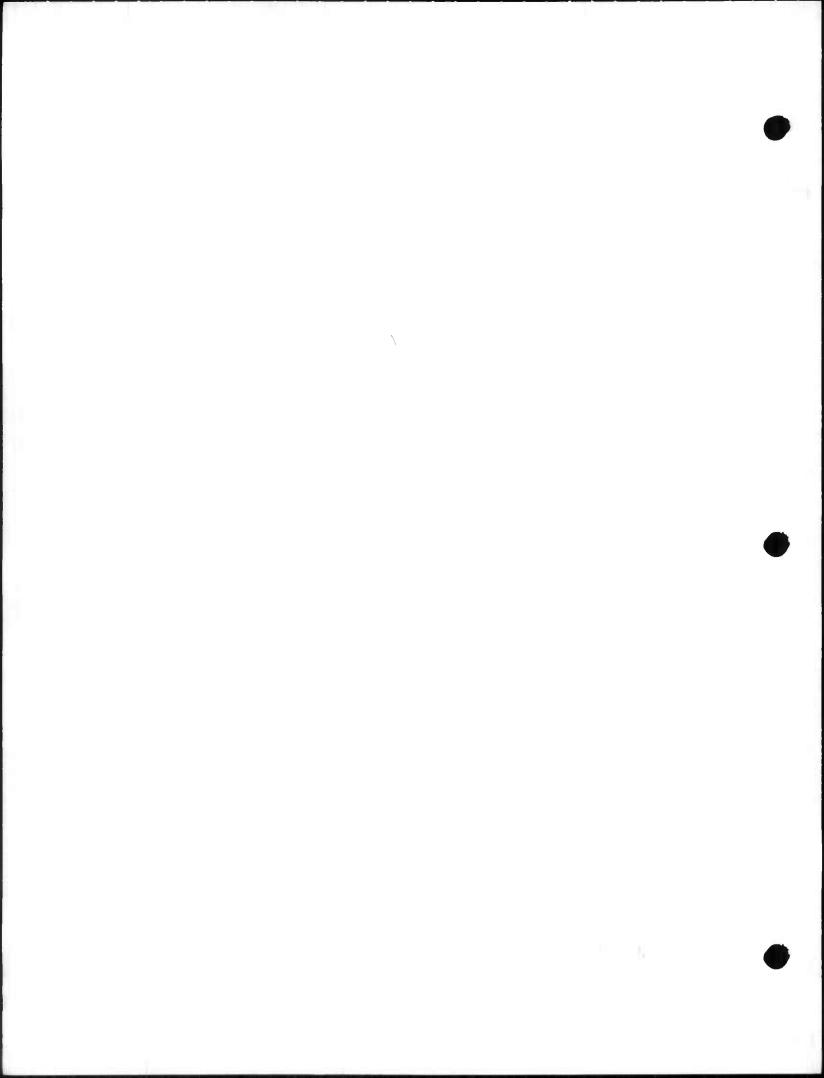
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

1 TES 2 NO 10g. CITIZEN OF WHAT COUNTRY 14. RACE — American Indian, Black, White, etc. Specify. White College 20c. LOCATION — City or Town, State Cockeysvill MD Approximate 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) DHMH-16 Rev 1/89

31. DATE FILEO (Month.

80

1993



## DIVISION OF VITAL RECORDS, P.O. BOX 68760,

15

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

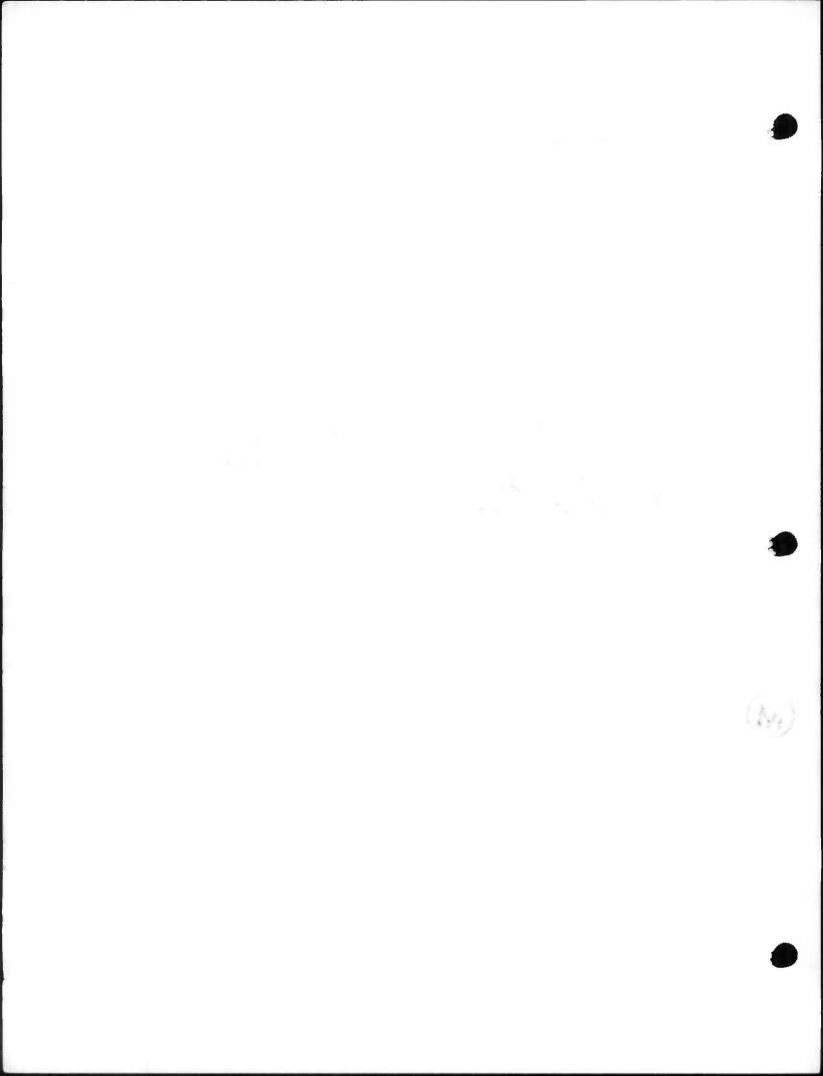
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.
The state of the s	1. DECEDENT'S NAME (First, Middle, Last) THERESE W, BOWEN  2. DATE OF DEATH MONTH APRIL DAY 6, 1978, 9. 404 M
	4. SOCIAL SECURITY NUMBER  5. SEX  6. AGE (In yrs. last birthday)  1   M 2   F   SEX  1   MONTHS   DAYS   HOURS   MIN.   DEC.   1   914   SERMANY
TOR	99. FACILITY NAME (If not imateuous, give street and number)  90. COUNTY OF DEATH  90. COUNTY OF DEATH  90. COUNTY OF DEATH  91. COUNTY OF DEATH  91. COUNTY OF DEATH
DIRECTOR	10e. CITY, TOWN OR LOCATION  10d. INSIDE CITY  LIMITS?  1 PYES 2 NO
FUNERAL	100. STREET AND NUMBER  5413 HIUBURN AVE  101. ZIP CODE  212.14  105. A  11. MARITAL STATUS  12. WAS DECEMBENT OF WERDING OF OUR OF A TO A TO A TO A TO A TO A TO A TO A
βÁ	11. MARITAL STATUS 1 Never Married 2 Merried 1 Never Married 2 Merried 3 Nidowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No- If yes, specify Cubert, Mexican, Puerto Rican, etc.) 14. RACE — American-Indian, Bleek, White, etc.: 1 YES 2 NO Specify:
LETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5 +)  16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  16b. KIND OF BUSINESS/INDUSTRY
E COMPLET	17. FATHER'S NAME (First, Middle, Last)  18. MOTHER'S NAME (First, Middle, Maiden Surmarne)  18. ADBARA ZINCHAND
TO B	19e. INFORMANT'S NAME (Type/Print) RECORDS  19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Jown, Stete, Zip Code) SAME AS ABOVE
	20b. PLACE AND DATE OF DISPOSITION   DATE   20c. LOCATION - City or Town, State
	They I gair mooth EVANS PUNERAL CHAPER
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, auch as cardiac or respiratory erreat, shock, or heart failure. List only one cause on each line.  Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Due TO (OR AS A CONSEQUENCE OF):  Onset and Death  / Yez/
NOIL	Sequentially list conditions, If any, leading to immediate    Due to (or as a consequence of):
CERTIFICATION	CAUSE (Disease or Injury that Initiated events resulting in death) LAST
	d
EDICAL	PART II. Other significent conditions contributing to deeth but not reaulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PREFORMED?  1 YES NO 22b. WERE AUTOPSY FINDINGS ANALBLE PRIOR TO COMPLETION OF CAUSE DE DEATH?
PHYSICIAN: MEDI	1  YES 2 NO
SICI	25. WAS CASE REFERRED TO MEDICAL  EXAMINER?  1  YES 2 NO
PH	27. MANNER OF DEATH  1 Netural 5 Pending  28e. DATE OF INJURY (Month, Day, Year)  (Month, Day, Year)  28c. INJURY AT WORK?  1 Netural 5 Pending
D BY	2 Accident Investigation M 1 YES 2 NO 3 Suicide 6 Could not be 26. PLACE OF INJURY — At home, lerm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, Chicago Chicago
LETE	A. Constitute destining
COMPLETED	298. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated.  2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) end manner as stated.
TO BE	29d. DATE, SIGNED (Month, Day, Year)  1031076  29d. DATE, SIGNED (Month, Day, Year)
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED/CAUSE OF DEATH (ITEM 27) (Type. Paint)  ORN ELi ASSON 9105 FRANKIN SY UR, BRIV, Ma 21237
	APR 08 1993 Julia Deutschen Andere

DIVISION OF VITA HELDENDS, P.O. BOX 13146,	5140, BALLIMORE, MARTLAND
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The second of the lost certificate be executed within 3.7 Yours after death. Page 6 may be retained by the hos	cuted within 🐎 Yours after death. Page 6 may be retained by the hos
TO THE FUNERAL DIRECTOR: After this certificals to the continue of the continue of the control o	nd completely filled in by the funeral director, page 5 should be detach purial, cremation, or removal.
IMPORTANT: if Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	tic event, the medical examiner must be notified at once.

1	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM			MENTAL HYGIENI REG. NO.					
1	1. DECEDENT'S NAME (First, Middle, Last) HELEN BADONI	EC				2. DATE OF DEATH	163 EAR	3. TIME OF DEATH 4 M			
	4. SOCIAL SECURITY NUMBER 219- 10-5741	5. SEX 6. AGE (1	YRS. MO	UNDER 1 YEAR NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 10/14/23	Coun	Balto., M			
	99. FACILITY NAME (If not institution, give street and number)  96. CITY, TOWN OR LOCATION OF GEATH  9c. COUNTY OF GEATH  9c. COUNTY OF GEATH  PAITTMORE										
) 15—	PRESIDENCE OF DECEDENT  100. STATE  10b. COUNTY  Md.			own on Local			10d. INSIDE CITY LIMITS? 1				
- 10	100. STREET AND NUMBER 2432 Fleet S	t.			ZIP CODE	2.4	10g. CITIZEN OF WHAT COUNTRY?				
	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 X NO	If yes, sp	ENOENT OF HISPAN ecity Cuben, Mexica NO Specifi						
	15. DECEDENT'S EDUC/ (Specify only highest grade of Elementary/Secondary (0-12) 8 th.	ATION completed) College (1-4 or 5 +)	SUAL OCCUPATION rk done during most of working retired.)								
	17. FATHER'S NAME (First, Middle, Last) Zigmond S	karuna	nome	Pmaker  16. MOTHER'S NAME (First, Middle, Malden Surname)							
	190. INFORMANT'S NAME (Type/Print) Thomas B.			ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  32 Fleet St. Baltimore, Md. 21224							
2	20e. METHOD OF DISPOSITION  K. Burlel 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	200	PLACE OF DISPOSITION	ON (Name of cer	netery, crematory or	20c. LOC	CATION — City or	Town, State			
:	Holy Rosary Cem. 4/8 Baltimore. Md.  21. SIGNATURE OF FUNERAL BETWEE UCHBEE  David J. Weber F.H. 401 S. Chester St.										
	23. PART I. Enter the diseases, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart feliure. List only one cause on each line.  IMMEDIATE CAUSE (Finel disease or condition resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):										
	Sequentielly list conditions, if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST  b. OUE TO (OR AS A CONSEQUENCE OF):  C. DUE TO (OR AS A CONSEQUENCE OF):										
;	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED?  1 □ YES 2 NO							IIb. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
	25. WAS CASE REFERREO TO MEDICAL EXAMINER?  HOSPITAL:  OTHER:										
	1 TYES 2 TO NO 27. MANNER OF DEATH	1 N Inpetient 2 ER/Outs  28a. DATE OF INJURY (Month, Day, Year)		Nursing Hon	TURY AT DRK?	NJURY OCCURED					
5	1 Netural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined	28e. PLACE OF INJURY	ACE OF INJURY — At home, farm, street, factory, office liding, etc. (Specify)			281. LOCATION (Street & City or Town, State)	end Number or Rural Route Number,				
	29e. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and menner ea stated.  2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) end manner as stated.										
	29b. SIGNATURE AND TITLE OF CERTIFIER  A R Novemi ~ 0  29c bjcense number  29d. OATE SIGN  ↓ 4/										
	30. NAME AND ADDRESS OF PERSON WHO 100N BROADWAY	CHURCH HO	SPITAL		AZEMT		į	_			
	APR 08 1993	22. HGIST AR'S SIN	THE RE								



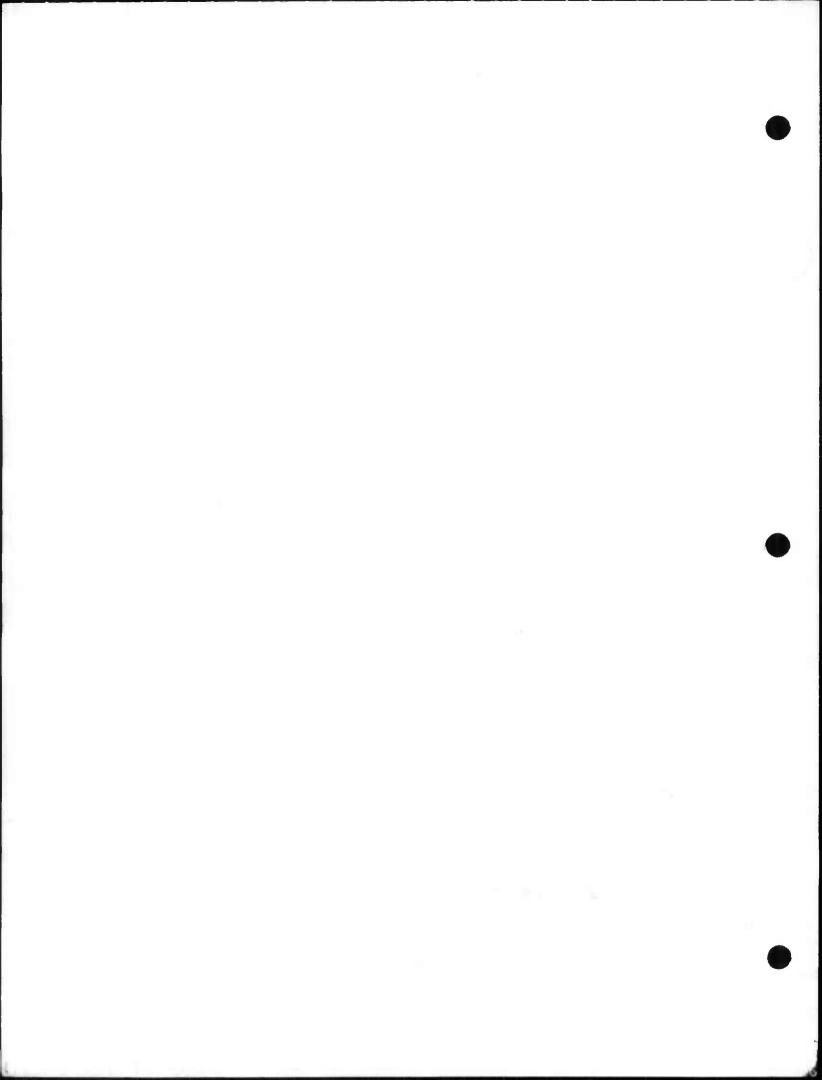
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	ICATE C	PE DEATH	REG.	NO.					
	1. DECEOENT'S NAME (First, Middle, Last)					2. DATE OF DEAT	H	3. TIME OF DEATH				
	ELLEN  4. SOCIAL SECURITY NUMBER	5. SEX 6. A	BOCK			April		931 2:4				
		1 M 2/C/0F	GE (In yrs. lest birthday)	MONTHS DAY		7. DATE OF BIRTH (Month, Day, Ye	1/)	. BIRTHPLACE (State or Foreign Country)				
	244-34-1080		72 YRS.		/N OR LOCATION OF D	10-8-	1920 .	S. Carolin				
œ	96. FACILITY NAME (If not institution, give at	9e. FACILITY NAME (If not institution, give atreet and number)					9c. COUNT	Y OF DEATH				
CTOR	UNION MEMORIAL RESIDENCE OF DECEDENT	HOSPITAL		BALTI	MORE CITY							
Æ	10e. STATE 10b. COUNTY			TY, TOWN DR LO	CATION			10d. INSIDE CITY				
DIRE	Md.	Baltimon	e	Ва	Ltimore			LIMITS?				
AL	10e. STREET AND NUMBER			101. ZIP CODE 10g. CITIZEN DF WHAT COUNTRY?								
E	1803 Summit +	lve.		21234 U.S.A.								
FUNERAL	11. MARITAL STATUS	R IN U.S. ARMED	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No.   14. RACE - American Indian,									
ВУ	1 Never Merried 2 Married 3 X Widowed 4 Divorced	1 🗆	specify Cuben, Mexic YES 2 ND Speci	nn, Puerlo Rican, etc fy:	.)	Specify: White						
	- William - Cara-an							WALTE				
1	15. DECEDENT'S EDUC (Specify only highest grade	completed)	16a. DECEDENT'S	USUAL OCCUP work done during se retired.)	ATION most of working	16b. KIND OI	16b. KIND OF BUSINESS/INDUSTRY					
7	Elementary/Secondary (0-12)	College (1-4 or 5+)	4.4	maker			,,,					
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		n ome	muren	Boursey areas		Home					
TO BE COM	Russell E. Dic	hanson			A Committee of the Comm	AME (First, Middle, Me						
	10a INFORMANT'S NAME (Tone/Dries)		10h MAII IN	ADDRESS (Com		ura Hoc						
	Mrs. CAtherine	Benkenker	mnen 82	17 M;	tnich Ro	R a 1+	N _J	2/22/				
	200. METHOD OF DISPOSITION		20b. PLACE AND DATE				LOCATION — CI					
	1 X Burial 2 Cremation 3 Remo	eval from State	Parkwood	ther place)		1						
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	rakkwood	Cemetery 4/10 Balto, Md.								
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ABDRESS OF FACILITY  Hartley Miller Funeral Home											
	7527 Hanford Rd. Balto. MD. 21234											
	23. PART I Enter the diseases, or complicatione that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximets Interval Between											
	timmeDIATE CAUSE (Finel disease or condition											
	resulting in deeth)	HCW	Te M	7								
		DUE TO (OH A	MAL CA		L rupt	410		121				
0	Sequentielly list conditions,	DUE TO (OR A	S A CONSEQUENCE O		2 1 000	wre		120 /				
AT	if any, leading to immediate cause. Enter UNDERLYING							Ì				
IFIC	CAUSE (Disease or Injury that initiated events	DUE TO (OR A	S A CONSEQUENCE O	F):	-							
ERTIFICATION	resulting in death) LAST											
O	PART II. Other algolificent conditions	contributing to deat	h but not requities	In the underly	don cause alver to	Part I or un	D AM ANTONOU	Total Merce Common Comm				
EDICAL				GIG GINGIT	y veese given in	PEI	S AN AUTOPSY RECHMED?	24b. WERE AUTOPSY FINE AVAILABLE PRIOR TO COMPLETION OF CAI				
						- 1 DAE	S 2 🖺 NO	OF OEATH?				
Ξ.						—		1 TYES 2 7 NO				
SICIAN:	25. WAS CASE REFERRED TO MEDICAL	-		26	26. PLACE DF DEATH (Check only one)							
SIC	EXAMINER?	HOSPITAL:	Outpatient 3 1 DOA	OTHER:	lome 5 - Residence							
Ξ	27. MANNER OF DEATH	28e. DATE OF INJUR	TY 286. TIN	E OF 28c.	INJURY AT	28d. DESCRIBE H		RED				
ΥP	1 Natural 5 Pending	(Month, Day, Yea	IN.	JURY M 1 [	WORK?  YES 2 NO							
D BY	2 Accident Investigation 3 Suicide 6 Could not be	28e, PLACE OF INJU	JRY — At home, ferm,			261. LOCATION (Street and Number or Rural Route Number,						
ETED	4 Homicide datermined	building, atc. (S	роспу)		City or Yown, State)							
15	290. CERTIFIER 1 CERTIFYING PHYSIC	IAN: To the best of my kn	lowledge, death occur	ed at the time of	late end place, and rhus	to the cause(a) end	menner as etated					
COMPL								cause(s) and manner as atat				
	29b. SIGNATURE AND TATLE OF CERTIFIER											
8	MANY M.D.		042	29c. LICENSE NUMBER  29d. DATE SIGNED (Morth, Day, Year)  47793								
입	34 HAME AND ADDRESS OF PERSON WHO		11117									
	AHMAD HAJJ, M.D. Vrion Memorial Hosp. 201 E. Univ PKwy, Balt, MD.											
	APR 08 1993	A Parida	A				/					
- 17		AND THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER.	man by the characteristics									



death. Page 6 may be retained by the hosp	e funeral director, page 5 should be detache I.	examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be fied within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING PHYS	TO THE FUNERAL DIRECTOR: After this of the filed within 72 hours after death with	IMPORTANT: If Item 28 is marked,	

	FOR 1 - STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAI	RTMENT	OF H	EALTH DEA	AND	MENTAL HYGIEN		13	09878	
	4 DECEMENT'S NAME (First Address Cont.)				eatom) <sub>CHEATON</sub>				2. DATE OF DEATH MONTH DAY 0.4 0.5		YEAR 93	3. TIME OF OEATH 2:30 P.	м
	4. SOCIAL SECURITY NUMBER 218 – 36 – 2978	5. SEX 1 💢 M 2 🗆 F	6. AGE (In yrs. les	yrs. last birthday) IF UNDER 1 YE			IF UNDER	MIN.	7. DATE OF BIRTH  3 - 1 - 4 1		BIRTHPLACE (State or Foreign Country)     S. C.		٦
R	9a. FACILITY NAME (If not institution, give street and number)  PRANCIS SCOTT KEY MEDICAL CENTER BALT:												
DIRECTOR	10a. STATE 10b. COUNTY	ENTER BALTIMORE  10c. CITY, TOWN OF LOCATION					CITY			10d. INSIDE CITY	=		
	MD 100. STREET AND NUMBER	Baltimone 10f, ZIP CODE					10g. CITIZEN			LIMITS?  1 X YES 2 NO WHAT COUNTRY?	4		
FUNERAL	4834 Midline F	21206					USA						
B∕	1 Never Merried 2 Married 3 Widowed 4 Divorced	RMED NO 13. WAS DECENDENT OF HISPAN If yes, specify Cuben, Maxica 1  YES 2 NO Specify					an, Puarto Rican, etc.)			14. RACE — American Indian, Black, Whita, etc. Specify. Black			
COMPLETED	15. OECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5	(G	CEOENT'S USUAL OCCUPATION ive kind of work done during most of working . Do NOT use retired.)					16b. KIND OF BUS	SINESS/INC	DUSTRY	51401	7
MPL	12th							Alfred Packing					
	17. FATHER'S NAME (First, Middle, Lest)  Arthur Cheatom								ME (First, Middle, Maiden Parret	Surname)			
TO BE	19a. INFORMANT'S NAME (Type/Print)						nd Number	or Rural i	I Route Number, City or Town, State, Zip Code)				
	Phyllis Cheate	om	20b. PLACE					ld./	Baltimor				4
	1X Buriel 2 Cremation 3 Remo		Balt	matory or o	thar place)	eme:	tery	/			impne, MD		
	22. NAME AND ADDRESS OF FACILITY  WM C. MARCH F.H./1101 E. NORTH AVE.										]		
_	23. PART I. Enter the diseasea, or compilications that caused the death. Do not enter the mode of dying, such as cardiec or reapiratory arrest, ahock, or heart feliure. List only one cause on each line.    Approximate interval Between Onset and Death disease or condition resulting in death)												
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d												
PHYSICIAN: MEDICAL	PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I.  24a, WAS AN AUTOPSY PREFORMED? 1 YES 2 NO  24b, WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO									\$			
SICIA	25. WAS CASE REFERRED TO MEDICAL  EXAMINER?  1 \( \tilde{\text{Y}} \) YES 2 \( \tilde{\text{NO}} \) NO  1 \( \tilde{\text{Inpatient}} \) Inpatient \( \tilde{\text{ERFOutpatient}} \) 3 \( \tilde{\text{DOA}} \) A \( \tilde{\text{Nursing Home}} \) 5 \( \tilde{\text{Residence}} \) 8 \( \tilde{\text{Other}} \) (Specify)										$\exists$		
ву РНУ	27. MANNER OF OEATH  1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 20 INJURY WORK?						28d. Describe how injury occurse  DRIVER IN AUTO/TRUCK IMP				PA	
	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY — At home, farm, atreet, tactory, office building, etc. (Specify)  ON ROAD						281. LOCATION (Street and Number or Rural Route Number, City or Rwn, State) PULASKI HWY AT 66th ST.					
COMPLETED	29a. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and dua to the cause(s) and manner as stated.  2 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										1		
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUMBER  O. C. M. E. 29d. DATE:						(Month, Day, Year)	1			
	MOWEN	COMPLETED CAUS	11		,	Str	eet	, B	altimore,	Ma	ryla	and 2120	1
	31. DATE FILED (Month, Dey, Year)  APR - 8 199		PENISTURE TO STATE OF THE STATE	Alanda	ė.								

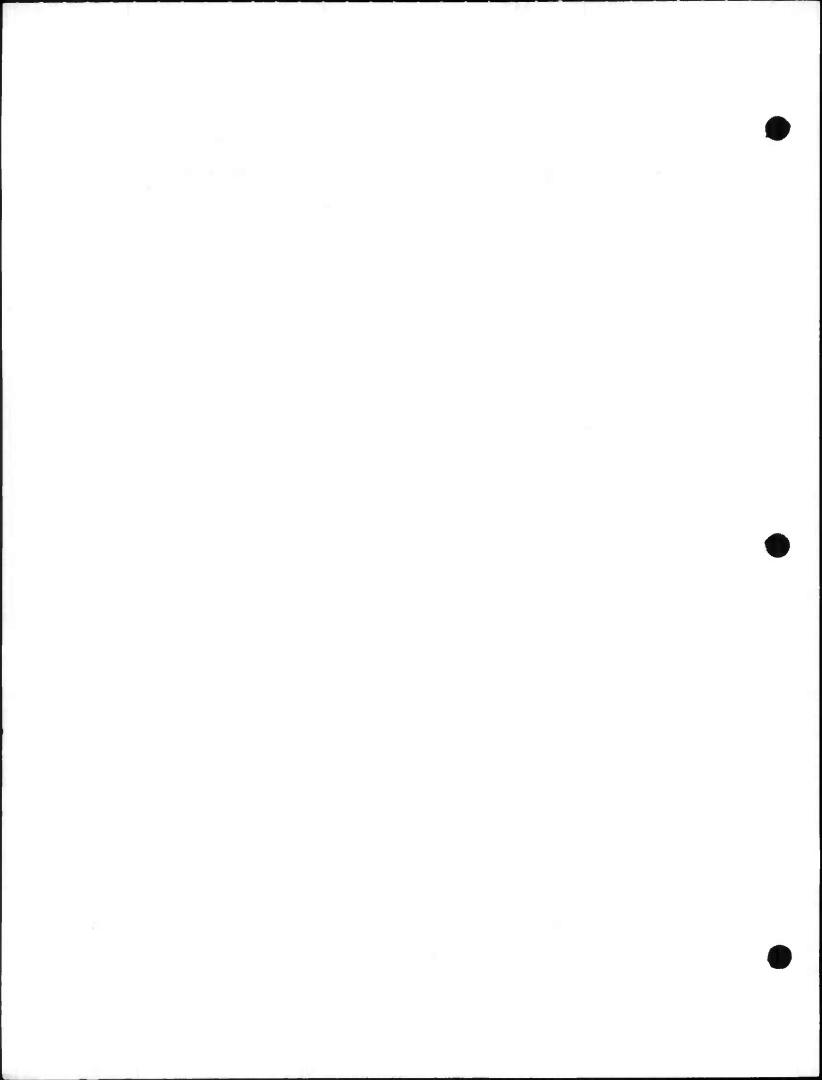


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	1 - FOR STATE REGISTRAR	STATE DF MAR	RYLAND / CI	DEPART	MENT OF	HEALTH AND	MENT	AL HYGIEN REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)							E OF DEATN			3. TIME OF DEATN	_
	Andrew J. Clark	e Jr.					Apr	il 7,	1993	YEAR	8:30 A	h
	4. SOCIAL SECURITY NUMBER	5. SEX 6. /	AGE (In yrs. les		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DAT	E OF BIRTH		8. BIRTH	IPLACE (State or Foreign	_
	214-40-4422	1 M 2 □ F G	92	YRS.	ONTHS DAYS	HOURS MIN.	Oct	nth, Day, Ybar)	90	Mai	ryland	
	9a. FACILITY NAME (If not institution, give				B. CITY, TOWN	OR LOCATION OF DE			_	INTY OF D	EATN	_
E	1542 Upshire Ro	ad			Balt	imore						
្ត	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNT	v		40- 0171	TOWN 00 100							=
DIRECTOR	Maryland			10c. C111,	Baltin						10d. INSIDE CITY LIMITS?	
	10e, STREET AND NUMBER										1 X YES 2 NO	
RA		a			"	of. ZIP CODE			1 -		VHAT COUNTRY?	
FUNERAL	1542 Upshire Roa	12. WAS DECEDENT EV	ED IN ILE AD	MED	1 40 1170 70	21218				S. I		_
	1 Never Married 2 Married	FORCES? 1 1	YES 2 T	40 IMED	If yea, s	CENDENT OF NISPAI pecify Cuban, Maxica	in, Puerto	IN? (Specify Ye Rican, etc.)	a or No—	14, RACE Black	— American Indian, L, White, atc.	
BY	3 Widowed 4 Divorced		WII		1 TYE	S 2X NO Specif	y:			Speci	White	
E	15. DECEDENT'S EDU (Specify only highest grade	JCATION	16a. DE	CEDENT'S U	SUAL OCCUPAT	ION	16	b. KIND OF BU	SINESS/IN	DUSTRY		_
	Elementary/Secondary (0-12)	College (1-4 or 5 +)	/Gi	Do NOT use	nk done durina m	lost of working	1					
[ ]	na	na		Draft	tsman			City	of B	altir	more	
COMPLET	17. FATHER'S NAME (First, Middle, Last)					16. MOTHER'S NA	ME (First,	Middle, Maiden	Sumame)			
BE (	Andrew J. Clarke	Sr.				Mar	у На	urris				
10	19a. INFORMANT'S NAME (Type/Print)					and Number or Rural						_
	Catherine Bruett	e (Niece)		4308 1	Nichola	s Ave.,	Balt	imore,	Md.	2120	06	
	20a. MÉTHOD OF DISPOSITION  1 X Burial 2 Cremation 3 Rem	noval from State	20b. PLACE	AND DATE OF	DISPOSITION (A	lame of	OA	TE 20c. LC	CATION -	City or To	wn, State	-
	4 Donation 5 Other (Specify)		New C	athedi	ral Cen			<b>10</b> Ba	ltim	ore,	Md.	
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE				and address of fa nunek Fun		Home				
	wellen	2				Brehms L			more	. Md.	21213	
	23. PART I. Entar the diseases, or shock, or heart failure.	complications that car	used tha de	ath. Do not	anter tha me	ode of dying, suc	h as ca	rdiac or resp	iratory ar	rest,	Approximate	_
	SHOCK, DI HEAR TAMUTE.	rist only our canse f	on auch iina									
) I	IMMEDIATE CAUSE (Finel	001									Interval Between Onset and Dear	
	disease or condition	Abdo	nural		c anu	mai						
		a. Abdo	AS A CONSEC	Gart,	c anu	pm						
NO	disease or condition resulting in death)	b	AS A CONSE	Contro	c anu	pm						
ATION	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	b	AS A CONSEC	Contro	c anu	pm						
FICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	b. OUE TO (OR .	AS A CONSEC	OUENCE OF):	c anu	pm						
TIFICATION	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING	b. OUE TO (OR .	AS A CONSE	OUENCE OF):	c anu	pm						
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AL CERTIFICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events	b. OUE TO (OR .	AS A CONSEC	DUENCE OF):			Pert I.	24a. WAS AN		24b.	Onset and Dea	ith
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APR 08 1993

32. REGISTRAR'S SIGNATURE



page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3

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BY

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COMPLI

BE

2

1 - Waturel

2 Accident

3 Sulcide

4 Homicide

(Check only one)

29b. SIGNATURE AND

5 Pending Investign

8 Could not be

determined

Truc

DIRECTOR: After this certificate hours after death with the State litem 28 is marked, or Item

director.

filled in by the funeral

DIVIS  THE HOSPITAL OR ATTE OTHE FUNERAL DIRECTOI NE filed within 72 hours after MPORTANT: If 16em 28	DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremati	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, it
DIVISIC  DITHE HOSPITAL OR ATTEND  THE FUNERAL DIRECTOR: A se filed within 72 hours after d  MPORTANT: If Item 28 Is	ON OF VIT	ING PHYSICIAN: T	After this certificate leath with the State	marked, or iter
THE HOSPITAL TO THE FUNERAL THE FILE WITHIN 72 MPORTANT: II	DIVISIO	OR ATTEND	DIRECTOR: ,	Item 28 Is
	_	THE HOSPITAL	THE FUNERAL be filed within 72 I	MPORTANT: IF

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. OECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH монтн 03 ROBERT EWAN CHRISTIAN 4. SOCIAL SECURITY NUMBER 5. SFX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year IF UNDER 24 HRS. 1 🖳 M 2 🗌 F 10-27-1910 216 24 5668 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR NORTH ARUNDEL HOSPITAL ASSOCIATION GLEN BURNIE RESIDENCE OF DECEDENT 10c. CITY. TOWN OR LOCATION Maryland Anne Arundel Co Pasadena FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 7740 Outing Avenue 21122 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) FORCES? 1 YES 1 Never Married 2 Merried IF YES, GIVE WAR OR DATES ВҰ 1 TYES 2 NO Specify. 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+) Rea 12 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Charles Merriweather Christian BE Grace 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City 2 Marie Christian 7740 Outing Avenue. Pasade 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 1 Burlel 2 Cremetion 3 Re 4 Deponation 6 Other (Specify) 22. NAME AND ADDRESS OF FACILITY Romald Wade, Dir Stat 4/7/93 655W.BaltimoreSt,balt ATT I. Entar tha diseases, or complications that ceused the death. Do not entar the mode of dying, such as cerdiac or shock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Final disesse or condition\_ resulting in death) DUE TE MEDICAL CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in dasth) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a, Y 1 🗌 PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) HOSPITAL: OTHER: 1 YES 2 THO e 5 - Residence 6 - Other (Speci 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF

93 09880

93

3. TIME OF DEATH

7:00 PM

10d. INSIDE CITY

RACE — American Indian, Black, White, etc.

1 YES 2 NO

White

8. BIRTNPLACE (State or Foreign

Maryland

A.A. COUNTY

USA

Specify

	RealEstate Broker										
AE (First,	IÈ (First, Middle, Maiden Surneme)										
	Christian										
oute Number, City or Town, State, Zip Code)											
Pasadena MD 21122  DATE 20c. LOCATION — City or Town, State											
i DAI	100.20		or rewil,								
ILITY C	State A	natom	z Boa	ard							
	palto,			-1 u							
ss cerdiec or respiratory errest, Approximate											
	Interval Between Onset and Death										
			[								
hard I											
Part I.	24a. WAS AN PERFOR	MED?	AM	RE AUTOPSY FINDINGS JLABLE PRIOR TO MPLETION DF CAUSE							
_	1 TES 2	E-NO	OF	DEATH?							
_			1 [	YES 2 NO							
ck only o	ne)										
□ Othe	er (Specify)										
-	SCRIBE HOW I	JURY OCCUR	ED								
261. LOC City	ATION (Street e or Town, State)	nd Number or I	Rural Route	Number,							
o the ce	use(e) end man	ner ee state-t									
			euse(e) end	d menner ee stated,							
BER		29d. DATE SI	GNED (Moi	nth, Day, Year)							
+		D 4/	2/9	3							
MAI	RYLAND	21122	,								
				DNMH-16 Rev 1/89							

1 YES 2 NO

29c. LICENSE NUMBER

D41927

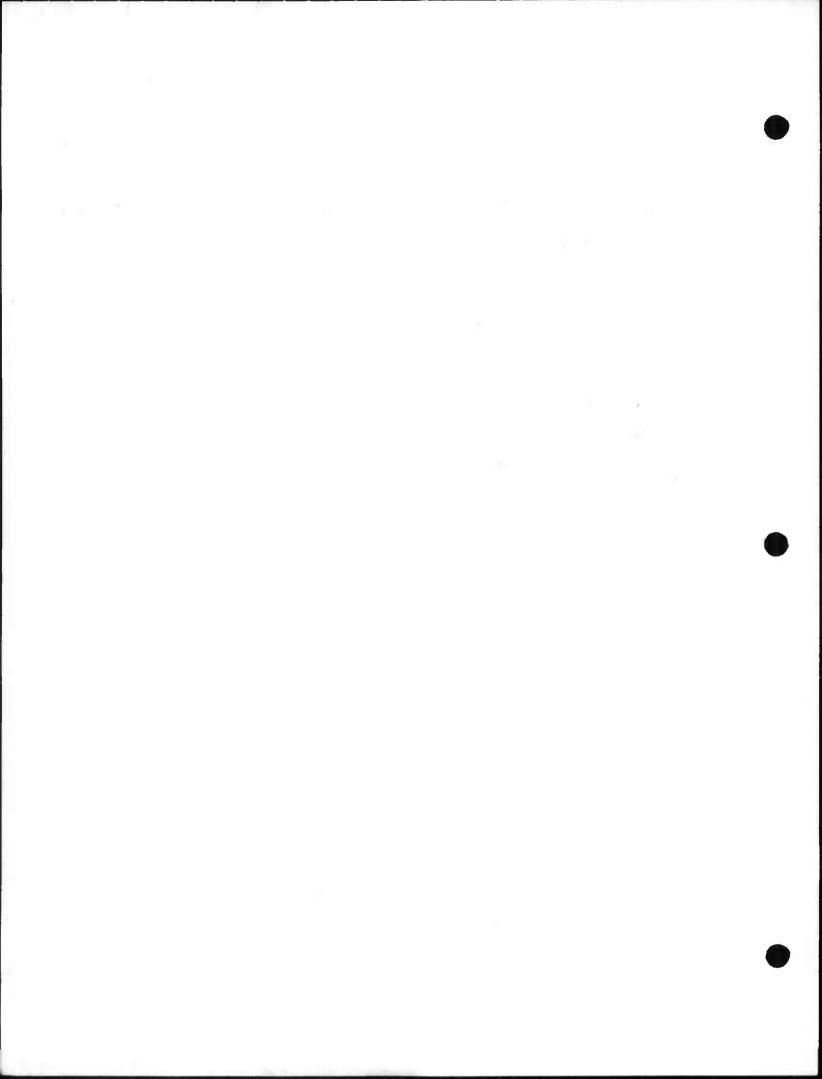
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) e

MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occured at the time, date end pli

OOROD I DREED III	LITTLD : 7 3 7 00 1	*,
DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATUR	RE
APR - 8 1993	fali Dendem Rando	4

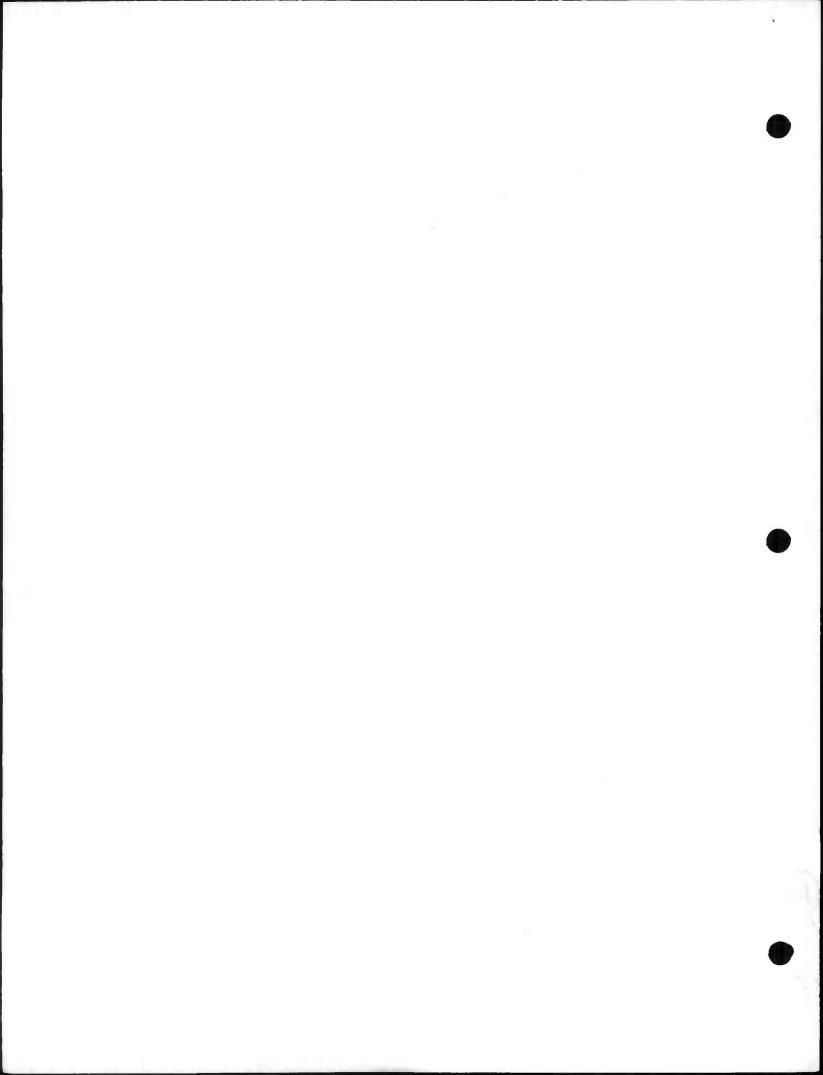
30. NAME AND ADDRUS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)



ON OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

AS.	112110. 25 1										_	•	
	1 - STATE REGISTRAR	STATE OF N	MARYLAND /	DEPAR ERTIF	TMENT	OF H	DEA'	AND I	MENTAL	HYGIEN REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE O	F DEATH			3. TIME OF DEATH
	MICHAEL I	J •	CAIN	J					0.4	04	199	YEAR	9:10 A M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les		IF UNDER	1 YEAR	IF UNDER	24 HRS	7 DATE OF	BIOTH	エフン		
	212-70-8074	1 XXM 2 □ F	29	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month.	7. DATE OF BIRTH (Morth, Day, Year) OCT. 4,1963  8. BIRTHPLACE (Statement of Country) MARYLANI			
	9e. FACILITY NAME (If not institution, give st	reet and number)			9b. CITY	, TOWN C	R LOCATI	ON OF DE	EATH		9c. COU	NTY OF DE	ATH
DIRECTOR	10 WADE AVE					CATO	)NSV]	LLE			BA	LTIM	ORE
Ä	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN C	OR LOCAT	ION					1	IOd. INSIDE CITY
		TIMORE			CA	TONS	SVILI	ĽΕ					LIMITS?
FUNERAL	100. STREET AND NUMBER					10f	. ZIP COD				10g. CIT	IZEN OF WH	IAT COUNTRY?
ÿ	10 WADE AVENUE						212	228				U.S.A	
5	11. MARITAL STATUS  12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES XX NO					WAS DEC	ENDENT O	F HISPAN	IC ORIGIN?	Specify Yes	or No-	14. RACE -	- American Indian, White, atc.
B	1 XXNever Married 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE W		••			XIX NO		n, Puerto Ric	en, atc.)		Specify:	
Ē	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed		CEDENT'S					16b. K	IND OF BU	SINESS/IND	DUSTRY	
	Elementary/Secondary (0-12)	rical	e retired.)	during mo.	St OF WORK	·V	- 1						
COMPLETED	11			TEC	HNIC	IAN		OF	TICA	L		5	
8	17. FATHER'S NAME (First, Middle, Last)				18. MOT	HER'S NA	ME (First, Mic	ldle, Meiden	Surnama)				
H	RONN R. CAIN  19a. INFORMANT'S NAME (Type/Print)  19b. MAIL							_	COMPTO				
2									Poute Number				
		FATHER)	1	LO WA	ADE AVENUE, CATONSVILLE, MARYLAN					LAND	212	28	
	20e. METHOD OF DISPOSITION  1 X Denies 2 Cremation 3 Remo	oval from State	20b. PLACE A	MADDATE O	oF DISPOS	ITION (Na	ma of		DATE	20c. LO	CATION —	City or Town, State  LLE, MARYLAND	
	4 Donation 5 Other (Specify)	el centre	LAKE	VIEW	MEM	ORIA	L PA	RK 4	/8/93	SY	CESVI	LLE, M	ARYLAND
	21. SIGNATURE OF PUNEMAL SERVICE DE	S ×	1		LE.	ROY	M. &	SS OF FAC	SELL	C. WI	ITZKE	FUNE	RAL HOMES
		-cza	-6		16	30 E	DMON	DSON	AVEN	UE, CA	ATONS	VILLE	,MD.21228
	23. PART I. Enter the diseesea, or c shock, or heart fallure. I	omplications that	caused the de	eth. Do n	ot enter	the mo	de of dy	ing, suci	n as cerdia	c or respi	ratory an	rest,	Approximate
	IMMEDIATE CAUSE (Finei	and only one out	oc on coon mie	:1									Interval Between Onset and Death
	disease or condition FATTY METAMORPHOSIS OF THE LIVER												
- 1	DUE TO (OR AS A CONSEQUENCE OF):												
NO	Sequentially list conditions, Due to (or as a consequence of):												
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	DOE 10 (	OH AS A CONSEC	DUENCE OF	):								
음	CAUSE (Disease or injury that initiated events	DUE TO	OR AS A CONSEC	DUENCE OF	n:								
E	resulting in death) LAST				r):							į l	
CE		•											+
AL	PART II. Other significent conditions							given in	Part I. 2	La. WAS AN			ERE AUTOPSY FINDINGS
PHYSICIAN: MEDICA	CHRONIC DRUG	ABUSE:	CHRONI	C AI	COH	OLI	SM		1	YES 2		C	OMPLETION OF CAUSE F DEATH?
ME									_	0			YES 2 NO
ä												1 '	
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:				-	ACE OF D	EATH (Che	ck only one)				
YSI	1 YES 2 NO	1 Inpetient 2 I	ER/Outpatient 3	□ DOA	OTHER		5X Re	eldence	6 🗆 Other (S	Specify)			
표	27. MANNER OF DEATH	28e. DATE OF (Month, Da	INJURY ly, Year)	28b. TIMI INJ	E OF JRY	28c. INJU			28d. DESCR	IBE HOW II	NJURY OC	CURED	
B	1 Natural Standing 2 Accident Investigation				М		ES 2	NO					
- 1	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF building, a	INJURY — At hou itc. (Specify)	me, term, s	treet, fect	ory, office			281. LOCATI City or	ON (Street a Town, State)	nd Number	or Rural Rou	te Number,
COMPLETED	29e. CERTIFIER												
MP	(Check only 1 CERTIFYING PHYSIC												
8	2 MEDICAL EXAMINER	Ou the name of ex	endor endor l	rivestigation	i, in my o	pinion, de	eth occur	ed at the	time, date en	d place, en	d due to th	e ceuse(e) e	nd menner se stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIED	Mit	- 140					NSE NUM					forith, Day, Year)
5	10	001					0.0	С.М.	E		0	4 – 05 -	-1993
• 1	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	E UP DEATH (ITEN	1 27) (Type,	Print)								



DIVISION OF VITAL RECORDS, P.O. BOX 68760

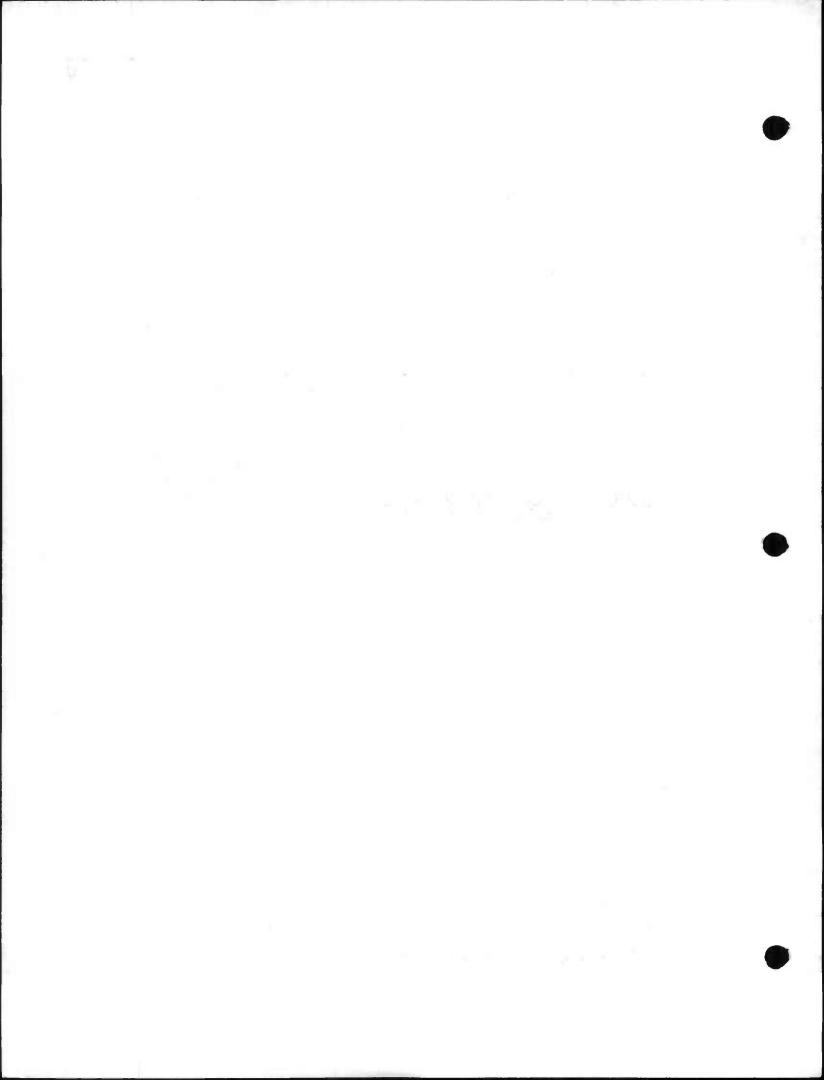
THE CONTROL OF THE CO
DR ATENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
hours after death with the State Dept. of Health and Mertal Hyglene prior to burnal, cremation, or removal.
Home 20 to marked as them 22 absume constitutions as able to describe about the second as a second as a second

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH ()4 07 1993 CASEY 04:39 ALLEN 4. SOCIAL SECURITY NUMBER 215-09-7967A 5 SFX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH B. BIRTHPLACE (State or Foreign DAYS 1/2/23/1916 Maryland 1 🔯 M 2 🗆 F 76 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL DIRECTOR RESIDENCE OF DECEDENT Baltimore 10d. INSIDE CITY Baltimore City MD YES 2 NO FUNERAL 10e. STREET AND NUMBER 21 206 109. CITIZEN OF WHAT COUNTRY? 4364 Parkside Drive 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES WAS OCCENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
 If yee, specify Cuben, Mexican, Puerto Rican, etc.)
 1 YES NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married BY sow Mite 3 Widowed 4 Divorced COMPLETED 18e. OECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16b. KINO OF BUSINESS/INDUSTRY Inspection Department Elementery/Secondary (0-12) College (1-4 or 5+) General Motors 17. FATHER'S NAME (First, Middle, Last)
Allen Wesley Casey SR Nellie H Childs BE 19a. INFORMANT'S NAME (Type/Print)
Catherine h Casey 19b. MAILINO ADDRESS (Street and Number of Rural Route Number, City of Town State 271200 2 27a. METHOD OF DISPOSITION
↑ Burlal 2 □ Cremation 3 □ Removal from State 20b. PLACE AND OATE OF DISPOSITION (Name of OATE Baltimore Town State Gardens Of Faith April 10,1993 4 Donetton 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Dippel Funeral Home 7110 Belair Road Baltimore MD 21206 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition Electomechancal 12 hr reaulting in desth) DUE TO (OR AS A CONSEQUENCE OF) obstuctie 10415 CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING Verous Stas", Cinno CAUSE (Disease or injury that initiated events QUE TO (OR AS A CONSEQUENCE OF) resulting in desth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 24-NO 1 YES 2 -NO-PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: patient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF OEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural
2 Accident 5 Pending Investigation 1 YES 2 NO BY 26s. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED. 8 Could not be 4 Homicide 29s. CERTIFIER 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, dasth occurred at the time, date and place, and due to the cause(e) and manner as stated. COMPL (Check only one) HOSPITAL FUNERAL within 72 H 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIONEO (Month, Day, Year) JO810 4-7-93 0 30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) Bellinin mo 21205 NC Tiomore hole 600

30 REGISTRAR'S SIGNATURE

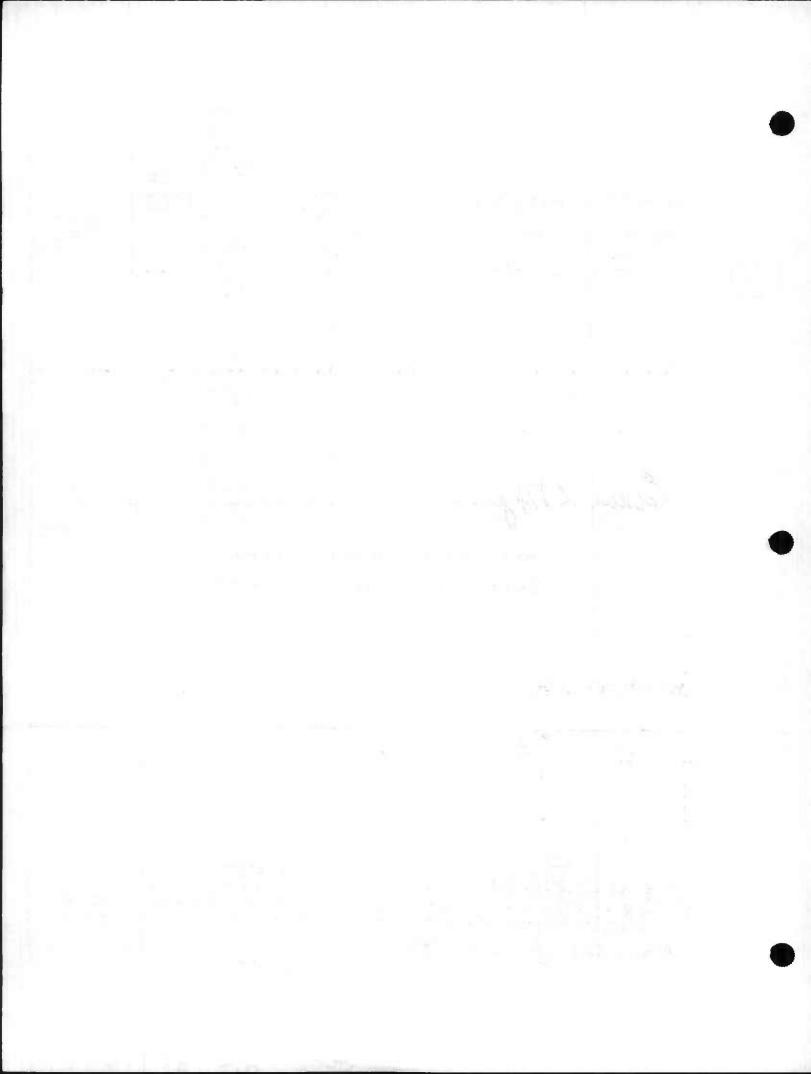
31. DATE FILED (Month, Day, Year)

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i	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
1	F

	1 - STATE REGISTRAR		CE	RTIF	CATE O	F DEATH	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	REG. NO	).		
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE C	F DEATH	AV	YEAR	3. TIME OF DEATH
	Florence Brown				Apri	1 1,1	[993	TEAN	10:00 P. M		
	4. SOCIAL SECURITY NUMBER	5. SEX (	8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.				. 7. DATE O	F BIRTH		8. BIRTH	PLACE (State or Foreign
DIRECTOR	213-42-7856	1 □ M 2 🛣 F	94	YRS.	MONTHS DAY		_	20, 1	L898	New	"Jersey
	98. FACILITY NAME (If not institution, give str  Potomac Valley Nu RESIDENCE OF DECEMENT	·	iter		Pocky	N OR LOCATION OF	DEATH			gome	
	10a. STATE 10b. COUNTY			10c. CITY	Y, TOWN OR LO	CATION				-	10d. INSIDE CITY
DIR	Maryland Montgo		Rocl	kville					5	1 YES 2 NO	
FUNERAL	1235 Potomac Vall				20851	. 3	33		S.A.	VHAT COUNTRY?	
BY	11. MARITAL STATUS  1 Never Married 2 Married  3 M Widowed 4 Divorced  12. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES				If yes,	ECENDENT OF HIS specify Cuban, Max ES 2 NO Spe	ican, Puarto Ri		a or No	Speci	E — American Indian, c, Whita, atc. My: hite
ED	15, OECEOENT'S EDUC (Specify only highest grade of		16a. DECE	EOENT'S	USUAL OCCUPA	TION most of working	16b.	KIND OF BU	ISINESS/IN	DUSTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	IIIe. E	Do NOT us	e retired.)			T			
N P	3	-	Hou	isew:	ire			lome	-4	_	
	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S	NAME (First, M Lancas		Sumame)		
BE	Henry Chapin Brow	VII	L					-			
2	Walter L. Childs.	Jr.			Blake	Lane C	akton,				24
	20a. METHOD OF DISPOSITION	<u> </u>			E OF OISPOSITI	ON (Name	OATE		OCATION		
	1 Exemple 2 Cremetion 3 Remove from State of cemetary, 4 Donation 8 Other (Specify) Hacke				k Cemet		Hackensack, New Jers				
	21. SIGNATURE OF FUNERAL SERVICE LICENTY Money & King Vienna Funeral Home, Inc. 171 W. Maple Avenue-Vienna, Va. 22180										
CERTIFICATION	disease or condition resulting in death)  a. ACTERIOLCIER OTIC HENCE DISEASE  DUE TO (OR AS A CONSEQUENCE OF):  B. CENERACIZED ACTERIOS CLEROSIS  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):										
CE	DART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDING.										. WERE AUTOPSY FINDINGS
PHYSICIAN: MEDICAL	ADVANCED A					PERFO	PRMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO		
SIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOODITAL				PLACE OF DEATH	(Check only on	9)			
Sic	1 TES 2 NO	HOSPITAL: 1   Inpatient 2	ER/Outpatient 3 [	□ DOA	OTHER:	lome 6 🗆 Residen	ce 6 🗆 Other	(Specify)			
BY PHY	27. MANNER OF DEATH  1 Netural 8 Pending 2 Accident Investigation	28a. DATE OF I (Month, Den		28b. TIM	JURY	INJURY AT WORK? YES 2 NO	28d. DE\$	CRIBE HOW	INJURY O	CCURED	
	3 Suicide 6 Could not be 4 Homicide detarmined		INJURY — At homete. (Specify)	ne, farm,	street, factory, o	ffice		ATION (Street or Town, State		er or Rural	Route Number,
COMPLETED	29a. CERTIFIER (Check only one)  1 CERTIFYING PHYSIC MEDICAL EXAMINE	CIAN: To the best of r									a) and manner as stated.
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIES	son, MI				29c. LICENSE	O	7	29d. DA	TE SIGNED	(Month, Day, Year)
-	30. HAME AND ADDRESS OF PERSON WHO	U, MD 1	6620 G	14 a ]	AUE, S	TE 114, S	LVE	L So	RIN(	-, M	030902
	APR - 8 1993	Julie Deur	S SIGNATURE	*							200



TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be esecuted within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for one as the burial-tran be filled within 72 hours after death with the State Dept. of Heath and Metals Hygiens prior to burial, cremation, or remaint.

IMPORTANT: If them 28 its marked, or them 23 shows any injury, or other transmatic event, the medical examiner must be notified at nace.

- 8 1993

							93	09884
	1 - FOR STATE REGISTRAR	STATE OF MARYL		TIMENT OF H		MENTAL HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Lest) STEVEN	LEWIS		CREE	ITR	2. DATE OF DEATH DO 3	ÿ 9'	3. TIME OF DEATH 12:32 A
	4. SOCIAL SECURITY NUMBER 217-06-6465	1 🗙 🔭 2 🗆 F	(In yrs. last birthday) 21 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 10-31-71		BIRTHPLACE (State or Foreign Country) ashington, DC
70R	9a. FACILITY NAME (# not institution, give st  ANNE ARUNDEL HO  RESIDENCE OF DECEDENT			ANNAPO	LIS	EATH	9c. COUNTY ANNE	OF DEATH ARUNDEL
DIRECTOR	10a. STATE 10b. COUNTY	ce Georges		y, town on locat	TON			10d. INSIDE CITY LIMITS? 1 YES 2 A ANO
FUNERAL	100. STREET AND NUMBER 13202 Miles Court				20708			OF WHAT COUNTRY?
BY FUN	17. MARITAL STATUS  1V Never Married 2 Married  3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 A NO	13. WAS DEC	ecify Cuban, Maxico	NIC ORIGIN? (Specify Yea in, Puarto Rican, etc.) y:		RACE — American Indian, Black, White, etc. Specify: White
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed)  College (1-4 or 5 +)	16a. DECEDENT'S (Give kind of life. Do NOT us	USUAL OCCUPATION Work done during mose retired.)	DN st of working	16b. KIND OF BUS		
BE COM	17. FATHER'S NAME (First, Middle, Last) Steven L. Creel, S	Sales	crerk		ME (First, Middle, Malden ia F. Clay	Sumame)		
10 E	Patricia F. Creel		19b. MAILING 1320	ADDRESS (Street a	nd Number or Aural Court, A	Property of Power	aurel,	MD 20708
	METHOD OF DISPOSITION  MA Burial 2 Cremation 3 Ramo  Donation 5 Other (Specify)  Signature of Fundamental Services	PANEL AND APPEAL TO	PLACE AND DATE	of disposition (Na the Cerrie ter	у	La		or Town, Stata Mary land
	· 1 dall	telead	de s	F1ec 7601	Sandy S	1 Home, In	Laur	el. MD 20707
	23. PART I, Enter the diseases, or o shock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	Omplications that cause on a	och line	YUNUS	de of dying, suc	h as cardiac or respi	refory arrest.	Approximate Interval Between Onset and Death
RTIFICATION	Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS A	CONSEQUENCE O	n				
	that initiated events resulting in death) LAST	DUE TO JOR AS A	CONSEQUENCE OF	1.				
MEDICAL CE	PART II. Other significant conditions	contributing to death b	ut not resulting	in the underlying	cause given in	Part I. 24s. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINOMOS AWALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PL OTHER:	ACE OF DEATH (Ch	dick anly one)		
BY PHYS	1 N YES 2 NO  27 MANNER OF DEATH  1 Netural 5 Pending 2 NAccident Investigation	1 □ Inpettent MXER/Outp  28s. DATE OF INJURY (Month, Dec. Mar)  3 - 26 - 199	28b. TIM	E OF 28c. INJ	URY AT	B C Other (Specify)  28d. DESCRIBE HOW IN  DRIVER IN		l l
	3 Suicide 6 Could not be 4 Homicide determined	28s. PLACE OF INJURY building, etc. (Spec	— At home, farm, i	2 10 0		281. LOCATION (Street a City or Yown, State) SOLOMONS		Rural Route Number,
COMPLETED		BAN: To the best of my knowl : On the basis of examination						use(s) and manner as stated,
TO BE	290 SIGNATURE AND TITLE OF CERTIFIER  30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) /5	(Percet)	O.C.M.			28 – 1993

111 Penn Street, Baltimore, Maryland

DHMH-16 Rev 1/89

21201

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

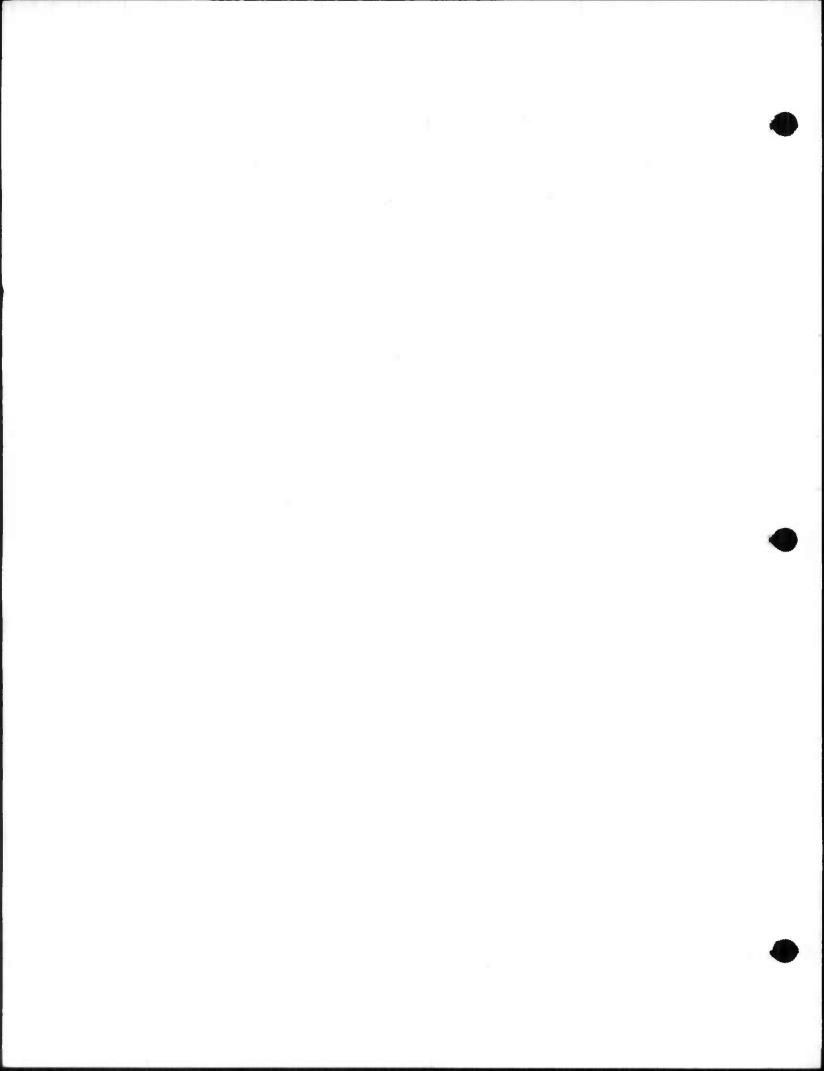
FOR 1 STATE

	REGISTRAR		CERTIF	ICATE OF	DEATH	REG. NO	).						
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH					
	Edna	E. DeMer	cado				6 19	93 4:50 P					
	4. SOCIAL SECURITY NUMBER	7	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	T	8. BIRTHPLACE (State or Foreign					
- 3	131-46-3259	1 M 2 (X) F	77 YRS.	MONTHS DAYS	HOURS MIN.	10/4/191	5	Jamaica					
CC						EATH	9c. COUN	TY OF DEATH					
DIRECTOR	Inns of the Ever	green-Northw	est	Balti	more								
입	10a. STATE 10b. COUNT	TY .	10c. CIT	Y, TOWN OR LOCA	TION			10d. INSIDE CITY					
E	Manuland		100					LIMITS?					
	Maryland 100, STREET AND NUMBER		B	altimore			,	1 X YES 2 NO					
FUNERAL	Additional Control of the Control of			1 "	H. ZIP CODE			EN OF WHAT COUNTRY?					
單	1800 Ingram Ro		21239		Un	ited States							
ا جُ	11. MARITAL STATUS	13. WAS DE	CENDENT OF HISPA	NIC ORIGIN? (Specify Y	s or No—	14. RACE — American Indian, Black, White, etc.							
	1 Never Married 2 Married	FORCES? 1 YES			S 2 💢 NO Speci	en, Puerto Rican, etc.)		Specific					
ВУ	3 🔀 Widowed 4 🗌 Divorced				2	•		Oriental					
8	15. DECEDENT'S EDI (Specify only highest grad		16a. DECEDENT'S	USUAL OCCUPAT	ION	16b. KIND OF BI	JSINESS/INDI	JSTRY					
<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT u	work done during n se retired.)	iost or working								
립	12 vr's		Ca	aretaker	•	Cr	ild C	are					
COMPLET	17. FATHER'S NAME (First, Middle, Last)					AME (First, Middle, Maide	Sumamal						
	Lascella De	Mercado				trude M. C							
B	19a. INFORMANT'S NAME (Type/Print)	Tier edde	404 444 844										
일	- Halling - In the second of t					Route Number, City or To	wn, State, Zip	Code)					
	Mr. Alfred Lee Yo			e as #10									
	20a. METHOD OF DISPOSITION 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Rer	novel from State	b. PLACE AND DATE	OF DISPOSITION (A		1		ity or Town, State					
	4 Donation 5 Dother (Specify)		New Cathe	edral Ce	meterv	4/12/93 Ba	ltimo	re.Maryland					
	21. SIGNATURE OF FUNERAL SERVICE L		rtsock, Jr.	22. NAME A	IND ADDRESS OF FA	ICILITY		. equipment of the control of the co					
	D. 1921	411		Leo	nard J. H	Ruck, Inc.							
	rang Lyg	why to		530	5 Harford	d Rd. Balt	imore.	Md 21214					
	23. PART I. Enter the diseases, or	complications that cause . List only one cause on e	d the death. Do	not enter the m	ode of dying, suc	ch as cardiac or rea	olratory arre	at, Approximate					
	IMMEDIATE CAUSE (Final	1	1 4					Onset and Deat					
	disease or condition resulting in death)	/6	relitar	ny				100000000000000000000000000000000000000					
1 1	resulting in death)	DUE TO (OR AS	A CONSEQUENCE O	en:									
- 1	_		AMI.A	wh/				İ					
CERTIFICATION	Sequentially list conditions, DUE TO JOR AS A CONSEQUENCE OF):												
¥	if any, leading to immediate cause. Entar UNDERLYING		,										
윤	CAUSE (Disease or Injury that initiated events  DUE TO (OR AS A CONSEQUENCE OF):												
E	resulting in death) LAST	(7)											
ايد	PART II. Other significant condition	ns contributing to death i	but not resulting	in the underlyis	ng cause given in			34b. WERE AUTOPSY FINDINGS					
DICAL	A 12 12 12 13 13 13 13 13 13 13 13 13 13 13 13 13				etille in Bright		RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE					
0						1 🗆 YES	3 🗌 NO	OF DEATH?					
Σ						_		1 T AER 5 WO					
PHYSICIAN:													
3	25. WAS CASE REFERRED TO SEDICAL EXAMINER?	HOSPITAL:			LACE OF DEATH (C)	neck only one)							
Š	1 🗆 YES 2 🗇 460	1 Inpatient 2 I ENOut	petient 3 🗆 DOA	OTHER:	me 5 🗆 Residence	6 [] Other (Specify)							
至	27. MANNER OF DEATH	28s. DATE OF INJURY	28b. Til	E OF 28c. IN	JURY AT	28d. DESCRIBE HOW	INJURY OCC	URED					
0	1 Matural 5 Pending	(Month, Day, Year)		4.4	ORK7 YES 2 NO								
- I		THE RESERVE OF THE PERSON NAMED IN COLUMN 1	Y - At home, from		CONTRACTOR	THE LOCATION COMM	and Manha	or Parel Brode Mander					
BY	2 Accident Investigation	3 Suicide 6 Could not be 28s. PLACE OF INJURY — At home, farm, street, factory, office 28s. LOCATION (Street and Number or Flural Route M											
ED BY	2 Accident Investigation	28e. PLACE OF INJUR- building, etc. (Spe	oflys										
8	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide dystermined	28e. PLACE OF INJUR faultding, etc. /Spe	ofly)										
8	2 Actident Investigation 3 Suicide 6 Could not be 4 Momicide 6 Centifying 29s. CEntifier (Check only)	28w. PLACE OF INJURY building, etc. (Spo SICIAN: To the best of my know	сту	ud at the time, dat	e and place, and du	to the cause(s) and m	nner sa state	d.					
8	2 Actident Investigation 3 Suicide 6 Could not be 4 Homicide 6 Could not be determined  29s. CERTIFIER (Check only)	SICIAN: To the best of my know	rledge, death occurr					d, cause(x) and menner as stated.					
COMPLETED	2 Actident Investigation 3 Suicide 6 Could not be 4 Homicide 6 Could not be determined  29s. CERTIFIER (Check only)	Building, etc. (Spo BCIAN: To the best of my know ER: On the basis of examination	rledge, death occurr		death occured at the	time, data and place, a	nd due to the	cause(x) and manner as stated.					
8	2 Actident 3 Suicide 4 Homicide  29a. CERTIFIER (Check only one) 2 MEGICAL EXAMIN	Building, etc. (Spo BCIAN: To the best of my know ER: On the basis of examination	rledge, death occurr			time, data and place, a	nd due to the						
BE COMPLETED	2 Actident 3 Suicide 4 Homicide  29s. CERTIFIER (Check only one) 2 MEGICAL EXAMIN  29s. SIGNATURE AND TITLE OF CERTIFIE	Building, etc. (Spo BCLAR: To the best of my know ER: On the basis of examination	riedge, death occurr on and/or investigation	on, in my opinion,	death occured at the	time, data and place, a	nd due to the	cause(x) and manner as stated.					
E COMPLETED	2 Actident Investigation 3 Suicide 6 Could not be determined 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMIN 29s. SIGNATURE AND TITLE OF CERTIFIE 30. NAME AND ADDRESS OF PERSON W	BUILDING, etc. (Spe BICLAR: To the best of my know ER: On the bests of examination ER	riedge, death occurr on and/or investigatio	on, in my opinion,	deeth occured at the	time, data and place, a	nd due to the	cause(x) and manner as stated.					
BE COMPLETED	2 Actident 3 Suicide 4 Homicide 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMIN 29s. SIGNATURE AND TITLE OF CERTIFIE 30. NAME AND ADDRESS OF PERSON W Allen Hettleman	SICIAJE: To the best of my know ER: On the best of examination	riedge, deeth occurr on and/or investigation A D EATH (ITEM 27) (Type 777 Reis	on, in my opinion,	deeth occured at the	time, data and place, a	nd due to the	cause(x) and manner as stated.					
BE COMPLETED	2 Actident Investigation 3 Suicide 6 Could not be determined 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMIN 29s. SIGNATURE AND TITLE OF CERTIFIE 30. NAME AND ADDRESS OF PERSON W	BUILDING, etc. (Spe BICLAR: To the best of my know ER: On the bests of examination ER	riedge, deeth occurr on and/or investigation A D EATH (ITEM 27) (Type 777 Reis	on, in my opinion,	deeth occured at the	time, data and place, a	nd due to the	cause(x) and manner as stated.					

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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 yours after death. Page 6 may be retained by the hospital	TO THE FUNERAL DIRECTOR; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal. cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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							93 (	9886
	FOR 1 - STATE REGISTRAR	STATE OF MARYL		IENT OF HEALTH AND ATE OF DEATH				
	1. OECEDENT'S NAME (First, Middle, Last)	SAMUEL	S. DUFF	AIE OF DEATH	2. DATE OF DE	ATH		TIME OF DEATH
	Samuel		DUFF		MONTH	19	93 P	2,22 P M
				UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIR (Month, Day,		8. BIRTHPLA Country)	NCE (State or Foreign
			86/ YRS.	NTHS DAYS NOURS MIN.	7-19-0	)6	Gasto	onia,N.C.
TOR	9a. FACILITY NAME (If not institution, give street Physical Ass. RESIDENCE OF DECEDENT	and number)	taspital t	A PATA	PEATH	9c 09U	AR	IKS
DIRECTOR	Maryland Char	les		own on location lata				d. INSIDE CITY LIMITS? YES 2 NO
FUNERAL	Rte 2 Box 2099	W	<u> </u>	10f. ZIP CODE 20646		10g. CITI	ZEN OF WHAT	T COUNTRY?
5		2. WAS DECEDENT EVER	IN U.S. ARMED	13. WAS DECENDENT OF HISP/ If yes, specify Cuban, Mexic			14. RACE — Black, W	American Indian, hita, etc.
BY	1 Never Married 2 Married 3 Wildowed 4XX Divorced	IF YES, GIVE WAR OR (	DATES	1 TYES 2 TNO Spec	tty:			ACK
Ī	15. DECEDENT'S EDUCAT (Specify only highest grade con		16a. DECEDENT'S USI (Give kind of work life. Do NOT use re	done during most of working	16b. KINO	OF BUSINESS/INC	OUSTRY	
COMPLETED	Elamentary/Secondary (0-12) 6th	College (1-4 or 5 +)		ntractor	Seli	F-employ	yed	
	17. FATHER'S NAME (First, Middle, Lest)  James Duff				AME (First, Middle,			
TO BE	19a. INFORMANT'S NAME (Type/Print) Samuel H. Duff/s	on		oness (Street and Number or Rura a. Ave., #203 F				
	20a. METHOD OF DISPOSITION 1 N Burlal 2 Cremation 3 Remova	20	b. PLACE OF DISPOSITE	ON (Name of cametery, crematory or		20c. LOCATION -	City or Town,	Stata
	4 Donation 5 Other (Specify)	ii iroiii suite	Harmony Me	morial Park		Landov		
	21. SIGNATURE OF FUNERAL SERVICE LICEN	GEE		Robert G, Ma	son Fund	eral Ho	me,Inc	•
$\dashv$	23. PART I. Enter the diseases, or con	polications that ceuse	ed the death. Do not	1661 Good Ho	ch es cerdiec o	r respiratory ar	sh.,DC	20020 Approximate
l l	shock, or heert failure. Lis							
- 1		t only one cause on	eech line.		- 1			Intervel Between Onset end Death
	IMMEDIATE CAUSE (Finel disease or condition	trie only one cause on	eech line.		- 1	are		
	IMMEDIATE CAUSE (Finel	Arte	eech line.	c Cardovosev	- 1	lake		
NOI	IMMEDIATE CAUSE (Finel disease or condition resulting in death)  Sequentially list conditions,	DUE TO (OR AS	roseled		- 1	lake		
CATION	IMMEDIATE CAUSE (Finel disease or condition recuiting in death)  Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS	A CONSEQUENCE OF):		- 1	lake		
IFICATION	IMMEDIATE CAUSE (Finel disease or condition recuiting in death)  Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted evente	DUE TO (OR AS	A CONSEQUENCE OF):		- 1	lake		
ERTIFICATION	IMMEDIATE CAUSE (Finel disease or condition resulting in death)  Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OR AS	A CONSEQUENCE OF):		- 1	lare		
Ö	IMMEDIATE CAUSE (Finel disease or condition recuiting in death)  Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted evente	OUE TO (OR AS	A CONSEQUENCE OF):  A CONSEQUENCE OF):	c Cardovosev	n Part i.   24a,	MAS AN AUTOPSY		Onset end Death  HRS S  ERIE AUTOPSY FINDINGS
Ö	IMMEDIATE CAUSE (Finel disease or condition resulting in death)  Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in death) LAST	OUE TO (OR AS	A CONSEQUENCE OF):  A CONSEQUENCE OF):	c Cardovosev	n Part i.   24a,		AM CO	Onset and Death  FLRSS
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ED BY PHYSICIAN: MEDICAL C	IMMEDIATE CAUSE (Finel disease or condition recuiting in death)  Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente recuiting in death) LAST  PART II. Other eignificent conditions of the cause cause. Examiner?  25. Was Case reference to Medical Examiner?  Yes 2 NO  27. Manner of Death  Natural 5 Pending Investigation	OUE TO (OR AS  OUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  COntributing to deeth  10 SPITAL:    Inpatient 2   ER/Out   Inpatient 2   Input	A CONSEQUENCE OF):  A CONSEQUENCE OF):  A CONSEQUENCE OF):  Dut not resulting in the consequence of the cons	the underlying ceuse given is  28. PLACE OF DEATH (C  THER: Nursing Home 5   Residence Y WORK? M 1 YES 2   NO	n Part i. 24a. 1 1 Check only one) 6 Other (Spec	MAS AN AUTOPSY PERFORMED? YES 2 NO  Sify) HOW INJURY OC (Street and Number	AM CO OF	Onset end Death  The state of t
ED BY PHYSICIAN: MEDICAL C	IMMEDIATE CAUSE (Finel disease or condition recuiting in death)  Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente recuiting in death) LAST  PART II. Other eignificent conditions of the cause of the	OUE TO (OR AS  OUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS	A CONSEQUENCE OF):  A CONSEQUENCE OF):  A CONSEQUENCE OF):  Dut not resulting in the consequence of the cons	the underlying ceuse given is  28. PLACE OF DEATH (C  THER: Nursing Home 5   Residence Y WORK? M 1 YES 2   NO	n Part i. 24a.  1   1   28d. Describe 28d. Describe 28f. LOCATION City or Town	NAS AN AUTOPSY PERFORMED? YES 2 NO  Official and Number 1, State)	AM CO OF OF Pural Pour	Onset end Death  The state of t
ED BY PHYSICIAN: MEDICAL C	IMMEDIATE CAUSE (Finel disease or condition resulting in death)  Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet initieted evente resulting in deeth) LAST  PART II. Other eignificent conditions of the conditions of th	OUE TO (OR AS  OUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS	A CONSEQUENCE OF):  A CONSEQUENCE OF):  A CONSEQUENCE OF):  Dut not resulting in the consequence of the cons	28. PLACE OF DEATH (CT Mursing Home 5   Residence WORK?  M   28c. INJURY AT WORK?  M   YES 2   NO et, factory, offica	n Part i. 24a.  1   1   250   260	AMS AN AUTOPSY PERFORMED? YES 2 NO  Office and Number (Street and Number 1, State)	AM CO OF 1 [	Onset end Death  The state of t
COMPLETED BY PHYSICIAN: MEDICAL C	IMMEDIATE CAUSE (Finel disease or condition resulting in death)  Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet initieted evente resulting in deeth) LAST  PART II. Other eignificent conditions of the conditions of th	OUE TO (OR AS  OUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS	A CONSEQUENCE OF):  A CONSEQUENCE OF):  A CONSEQUENCE OF):  Dut not resulting in the consequence of the cons	the underlying ceuse given in the un	n Part i. 24a, 1 1 Check only one) 26 Other (Special Describer 28f. LOCATION City or Town	NAS AN AUTOPSY PERFORMED? YES 2 NO  Sify) HOW INJURY OC (Street and Number in, State)  and manner as states, and due to the states indices in the states in the states in the states in the states in	AM COOP 1 [	Onset end Death  The state of t
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed very THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and comple filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, or lifem 28 is marked, or item 23 shows any injury, or other traumatic events.

DIVISION OF VITAL RECORDS, P.O. BOX 68700.

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								(	93	09887
	1 - FOR STATE REGISTRAR	STATE OF MA			NT OF HEAL		MENTAL HYGII			
	1. DECEDENT'S NAME (First, Middle, Last) MARY			DRIDGE			2. DATE OF DEATH MONTH APRIL 6	DAY	YEAR	TIME OF DEATH
	220 00 0000	1 - M 2 X-XF	AGE (In yrs. lest	YRS. IF UN		NDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year, 7 - 19 -	T	8. BIRTHPL Country)	ACE (State or Foreign
TOR	90. FACILITY NAME (# not institution, give stre THE JOHNS HOPKIN RESIDENCE OF DECEMENT		AL	9b. C	BALTIMOI			7,500,000	TIMO	RE CITY
DIRECTOR	10a. STATE 10b. COUNTY				NOR LOCATION					Od. INSIDE CITY LIMITS?  YES 2 NO
FUNERAL	1838 N. Wolfe	St.			10f. ZIP 0	213		US/	EN OF WHA	AT COUNTRY?
B	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT I FORCES? 1 FYES, GIVE WAF	YES 2 [Y]NO		13. WAS DECENDEN If yes, specify C 1 YES 2	uban, Mexica	IIC ORIGIN? (Specify n, Puerto Rican, etc.)	Yea or No-	Black, V	- American Indian, White, atc.
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION ompleted) College (1-4 or 5 +)	(Give	EDENT'S USUAL Skind of work do DO NOT use retire Sable	ne during most of wi	orking	16b. KIND OF	BUSINESS/INDL		
BE CON	17. FATNER'S NAME (First, Middle, Lest) Austin Eldridge					other's ha	ME (First, Middle, Maid	den Surname)		
TO B	190. INFORMANT'S NAME (Type/Print) ROSIE Crowder			MAILING ADDR 838 N			Poute Number, City or / Baltim			1213
	20e, METHOD OF DISPOSITION V Burlet 2 Cremation 3 Remov		20b. PLACE AN	alvar	*		Α	nne Ai		
	21. SIGNATURE OF FUNERAL SERVICE LICES	Good			WM C. N	1ARCH	F.H./1	101 E.	. NO	RTH AVE.
	23. PARTY: Enter the disease, or co abock, or heert failure. Li IMMEDIATE CAUSE (Final disease or condition resulting in death)	DUE TO (O	R AS A CONSEQU	2 MIN	4 se	0515				Approximate Interval Batween Onset and Daath
CERTIFICATION	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events resulting in death) LAST	Se Vé	R AS A CONSEOL	Nal 11	grenou utrit		ecubit	al ulc	cers	month s
PHYSICIAN: MEDICAL C	PART II. Other algnificent conditiona  SEVERE QUE  CVA E RI	contributing to de			underlying caus	e given in	PERF	AN AUTOPSY FORMED?	AM CC OF	ERE AUTOPSY FINDINGS MAILABLE PRIOR TO DMPLETION OF CAUSE F DEATH?  YES 2 NO
YSICIAN	1 TES 2 NO	HOSPITAL:	R/Outpatient 3	DOA 4	IER:	F DEATN (Che	ock only one)  6  Other (Specify)			
B	27. MANNER OF DEATN  1 Netural 5 Pending 2 Accident investigation 3 Suicide 8 Could not be 4 Homicide detarmined	28a. DATE OF IN. (Month, Day. 28a. PLACE OF II building, atc	Year)  NJURY — At hom	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES		28d. DESCRIBE NOT 281. LOCATION (Stre City or Town, Sta	et and Number o		le Number,
COMPLETED	29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICI.									nd manner as stated.
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	Bellar	e MC	)	1	2012		29d. DATE	SIGNED (M	onth, Day, Year)

(Check only one)

1 CERTIFYING PRISIDIAN: To the beat of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Typo, Print)

LORRAINE B. WARE MD, JOHNS HOP KINS HOSPITAL, 600N WOLFEST, BACTO MD

31. DATE FILED (Month, Day, Year)

32. REGISTBAR'S SIGNATUPE

APR - 8 1993

APR - 8 1993 LORRAINE B. W.
31. DATE FILED (Month, Day, Veer)
APR - 8 1993

5-160

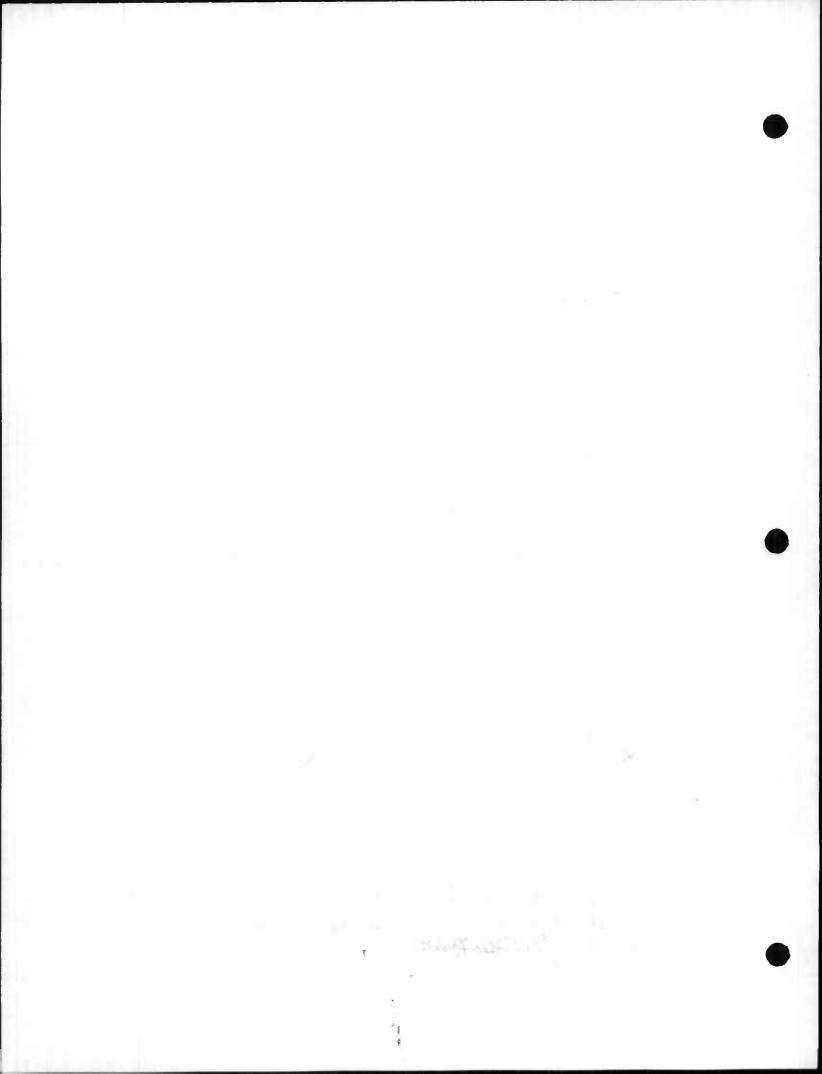
FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	Janne
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		1. DECEDENT'S NAME (First, LOUISE	Middle, Last)	ELDI	RIDGE						2. DATE O	F DEATH DA	ž	YEA93	3. TIME OF DEATH
		4. SOCIAL SECURITY NUME	ER	5. SEX		rs. lest birthday)	IF UNDER 1	YEAR	IF UNDER 2	24 HRS.	7. DATE O	F BIRTN	<u>о</u> Т		9:45 AM M
pinous		213-28-1754 9a. FACILITY NAME (# not in		1 M 2 XF	68	YRS.		DAYS	HOURS OR LOCATIO	MIN.	8/1	4/24		Char	hico, MD
1, 2, 3 st	ECTOR	4427 23rd	Parkw	44	2				Hills				Prin		George's
. Pages	DIREC	10e. STATE MD	10b. COUNTY	ce George	e's		y, town or emple								10d. INSIDE CITY LIMITS?
sit permi	ERAL	104. STREET AND NUMBER 4427 23rd	Parkw	ay				101	f. ZIP CODE					EN OF W	1 X YES 2 NO
the burlal-transit permit. Pages	BY FUNE	11. MARITAL STATUS 1 Never Merried 2 3 Widowed 4 Divo	Married	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES :	2 <b>N</b> O	14	yes, sp	ecify Cuben	NISPANI , Mexican Specify:	n, Puerto Ric	(Specify Yes can, etc.)		14. RACE Black Specifi	— American Indian, , White, etc. y:
use as	COMPLETED	(Specify only Elementary/Secondary (0	EDENT'S EDUC highest grade	CATION completed) College (1-4 or 5 d	_	Give kind of life. Do NOT us	work done du	CUPATIO	ON ost of working		16b. I	(IND OF BUS	INESS/IND		ack
detached once.	COMP	3 17. FATNER'S NAME (First, MI				Cook		_	18. MOTNE	ER'S NAM	ME (First, Mi	Rest	Surname)		
5 should be notified at	TO BE	Joseph F.				19b. MAILING	ADDRESS (	Street a	and Number o	or Rural R	oute Numbe	ene S	, State, Zip	Code)	
page 5	ř	Edward Hem:	ON		20b. PL	6613	North	am	Road	, Te	mple	Hills	, MD	20	748
il director, p		1 Duriel 2 Cremetio 4 Donation 8 Other 21. SIGNATURE OF FUNERAL	(Specify)			cy, crematory or o	oin C	eme			4/1/9	3 Bre			
the funeral di yal.		Due.	n 7	Temm	ines	#900	Ro	ber 61	Good	Mas	on Fu e Roa	meral	E V	VDC	nc. 20020
and completely filled in by the funeral director, page 5 should be detached for burial, cremation, or removal. natic event, the medical examiner must be notified at once.		23. PART I. Enter the di- ahock, or he IMMEDIATE CAUSE (Fin disease or condition resulting in death)	er Clanure.	e. MET	437	ATICONSEQUENCE OF			de of dyln				atory srre	est,	Approximate interval Batween Onset and Death
ending physician I Hygiene prior to or other traun	ERTIFICATION	Sequentially list conditi- if any, leading to immed csuse. Entar UNDERLYII CAUSE (Disease or Inju- that initiated eventa resulting in death) LAST	liete NG Ty			PHSEQUENCE OF									
signed by Health and Ws any I	MEDICAL C	PART II. Other significat	nt condition	a contributing to	death but (	not resulting (	n the unde	erlying	g cause gi	ven in P		4a. WAS AN A PERFORM	ED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF OEATH?  1  YES 2 NO
Dept 23	SICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL					28. PL	ACE OF DEA	ATH (Chec	ck only one)				
the the	HYSIG	1 Tes 2 No		HOSPITAL: 1 Inputient 2 I		nt 3 🗆 DOA			5 KResi	-					
After this c death with s marked,	ву Р	1 Natural 5 F	ending restigation	(Month, Da	iy, Year)	INJ	URY M	WO	URY AT RK? (ES 2	- (	28d. DESCI	RIBE NOW IN	JURY OCCL	JRED	
after 28	ETED	4 Homicide d	could not be elarmined	28e. PLACE Of building,	atc. (Specify)	Al home, lerm, a	treet, lectory	, offica			281. LOCAT City or	ION (Street an Town, State)	d Number o	r Rural Ro	ute Number,
40=	COMPL	2 MEOIC	CAL EXAMINER												and manner es atated.
TO THE FUNERA  be filed within 7  IMPORTANT: 1	TO BE	29b. SIGNATURE AND TITLE (	(	Denni	isl	Fin	elra	X	29c. LICEN	SE NUME	O Z	2	29d. DATE	SIGNED (	Month, Day, Year)
		DEIVNIS F	1. PB	RIEBAT	/	110I	RVI	NE	55	(-, 1	NW	WAS	HIM	Gran	1,DC 20010
V		APR 08 19		132. Aprilistraci	an-Many	起									

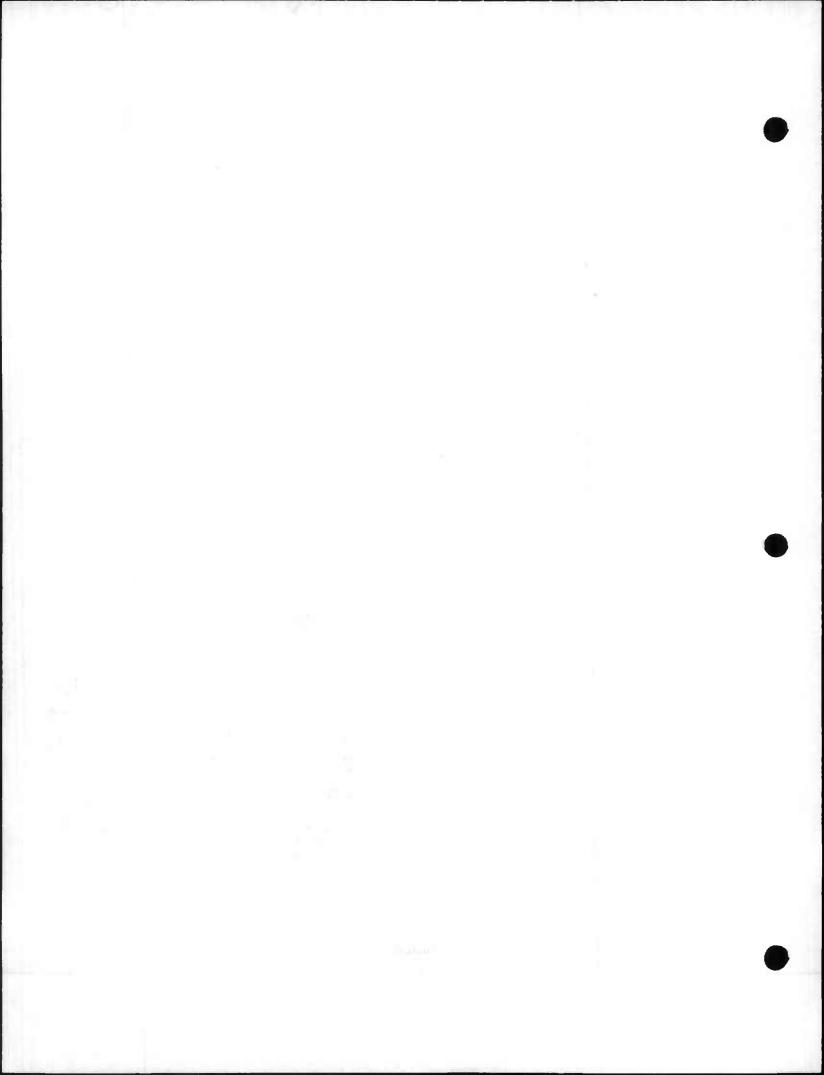
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



BALTIMORE, MARYLAND 21215-0020

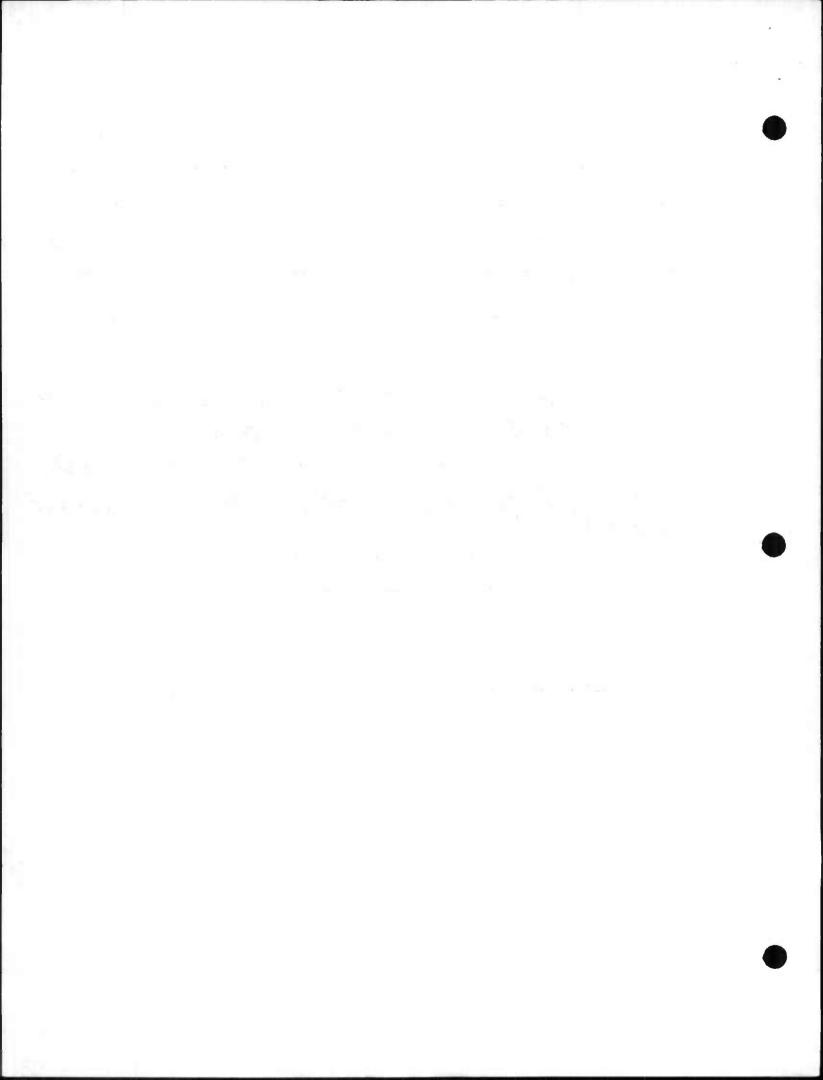
THE HOSPITAL OR ATENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  WPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART			MENTAL HYGIEN	E	3 03003
1	1. DECEDENT'S NAME (First, Middle, Last)	FOLUE				2. DATE OF DEATH	AV V	3. TIME OF DEATH
	LAURA A.	FOWKE:				04 08		93 05:12 A M
1	521-33-4672	1 M 2 F 21	YRS.	ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Sept. 8,1	971	Country Colorado
DIRECTOR	THE JOHNS HOPKIN		5		ORE CITY	ATH	9c. COUNTY	OF DEATH
EC	10a. STATE 10b. COUNT	Υ	10c. CITY,	TOWN OR LOCAT	ION			10d. INSIDE CITY
	Colorado		A:	rvada				1 XYES 2 NO
FUNERAL	100. STREET AND NUMBER 6208 Union S	treet		101	80004		1	of what country?
BY	11. MARITAL STATUS 1 Never Merried 2 Married 3 Divorced	12. WAS DECEDENT EVER II FORCES? 1 TYES IF YES, GIVE WAR OR D	2 3NO	If yes, spi		C ORIGIN? (Specify Ye., Puerto Rican, etc.)	8 or No- 14	RACE — American Indian, Black, White, atc. Specify: White
	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16e. DECEDENT'S US	BUAL OCCUPATION	N st of working	18b. KIND OF BU	SINESS/INDUS	TRY
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	Stude:	k done during mo netired.) nt	at the second reg	Metropol	itan S	State College
BE CO	17. FATHER'S NAME (First, Middle, Lest)  Charles D. F	owkes			18. MOTHER'S NAM	F. Stiles		
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DDRESS (Street a	nd Number or Rural R	oute Number, City or Tow	m, State, Zip Co	rde)
-	Mary F. Fowkes			e AS #1				
Ì	20e. METHOD OF DISPOSITION 1	cen	PLACEAND DATE OF	DISPOSITION (No ELVICE	Corp. 4-9	9-93 TOW		y or Town, State iaryland
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	0		D ADORESS OF FAC		Tue	
	Wallace	S. Brook	31 In.	1050	Vork Pos	uneral Hon	MA C	1204
	23. PART I. Enter the diseases, or shock, or heart failure.  IMMEDIATE CAUSE (Final disease or condition	List only one cause on e	ach line.	,	0		iratory arres	Interval Between Onset and Death
	resulting in death)	8. Severe (	y to-mea	julovu	us Men	imenutis		3 weeks
z			CONSEQUENCE OF:					78 days
5	Sequentially list conditions, if any, leading to immediate	A 1			0 1			1
	cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events		Melo CL	nous	leules	na		6 Mos tho
CERTIFICATION	resulting in desth) LAST	d.	odidio: «					
	PART II. Other significant condition	ns contributing to death b	ut not resulting in	the underlying	t cause alven in i	Part I. 24a. WAS AN	Almoney	24b. WERE AUTOPSY FINDINGS
CAL	Corett Vers	11.54		are orderlying	Cause given in i	PERFO	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
PHYSICIAN: MEDIC	Renal Ja	elune				1 _ YES	I I NO	OF DEATH?
ä	0					Est la co		
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PL	ACE OF DEATH (Che	ck only one)	_	
IXSI	1 VES 2 NO	1 hpatient 2 ER/Outp	atlent 3 DOA 4	☐ Nursing Hom	5 🗆 Residence			14
BY PH	1 Netural 5 Pending 2 Accident Investigation	28s. DATE OF INJURY (Month, Day, Year)	28b, TIME (	WO WO	URY AT RK? 'ES 2 NO	28d, OEŞCRIBE HOW	INJURY OCCUP	RED
	3 Suicide 8 Could not be 4 Homicide datermined	28e. PLACE OF INJURY building, stc. (Spec	— At home, ferm, stre	et, fectory, office		281. LOCATION (Street City or Town, State,	and Number or	Rural Route Number,
COMPLETED	22-1	ICIAN: To the best of my know						ause(a) and menner as stated.
	296. SIGNATURE ANO, TITLE OF CENTIFIE			-	29c. LICENSE NUM			
BE	Kellin K Kom	- Lua D	sicur		A STATE INCH	PLT1		18 (93
2	30. NAME AND ADDRESS OF PERSON WI			rint)				
į	Kellen K Kov			has Ho	pkins b	lospital,	Baltin	rose Maryland.
	31. DATE FILED (Month, Day, Year)	32/REGISTRAR'S SIGN	ATURE A-Aandell			1		



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

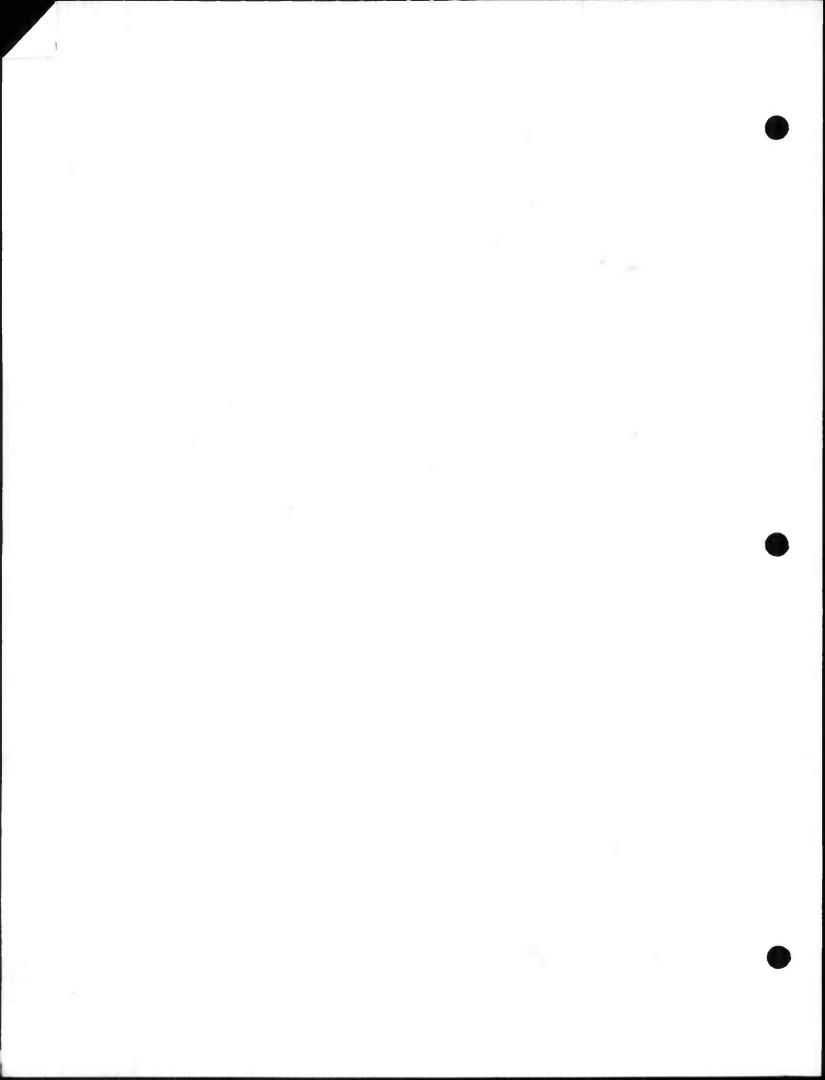
		1. DECEDENT'S NAME (First, Mic	ddle, Last)	-						2. DATI	E OF DEATH		1.	. TIME OF DEATH
		JOSE	PHIN	E LOU	TSE FI	LLER				0 4	TH D	AY 7 O	YEAR	
		4. SOCIAL SECURITY NUMBER	5	5. SEX	6. AGE (In yrs. les		IF UNDER 1 YE	AR IF UNI	DER 24 HIRS.	+	0.5 OF BIRTH	199		2:00PM M
		216-03-285	n	1 🗆 M 🛣 🗗 F	7.5		NONTHS DA	_		(Mon	th, Day, Year)		Country)	
pinous		9a. FACILITY NAME (If not institu	_	reet and number)	/ -		9b. CITY, TO	MN OR LOCA	TION OF D		19/19	7	MAI	RYLAND
	DIRECTOR	G.B.M.C.,6	701	N.CHAR	LES STE			WSON					TIMOI	
es 1,	ည္ထ	RESIDENCE OF DECED	b. COUNTY			10c. CITY.	TOWN OR L	OCATION					1	od. INSIDE CITY
permit. Pages	E	MARYLAND	BAL	TIMORE			LTIM							LIMITS?
ermit	_	10e. STREET AND NUMBER				DA	17 1 11	101. ZIP CO	DDE			10g. CITI		AT COUNTRY?
ısıt	FUNERAL	8225 EVERG.	REEN	DRIVE				2	1234			(	1.5	A.
020 physician. burial-transit	S S	11. MARITAL STATUS			T EVER IN U.S. AR			DECENDEN'	OF HISPA		N? (Specify Ye	or No-		- American Indian,
the first	B≺	1 Newer Married 2 Mer 3 Widowed 4 Divorced			MAR OR DATES	••		YES 2 N			rican, etc.)		Specify:	White, ele-
	ETED	15. DECEDE (Specify only hig				CEDENT'S U			dias	16	b. KIND OF BU	SINESS/IND	USTRY	
12 P		Elementary/Secondary (0-12)		College (1-4 or 5	- Ho	Do NOT use	retired.)	/1500	wing			_		
AND the hospital detached to	COMPL	17. FATHER'S NAME (First, Middle	Last)		170	SIVIE	1114	LEK	YTHEO'C NA	ME (Fint	Middle, Maidea	C		
2 2 2 Z	6 ш	GEORGE	HE	NRY	SCHL	EIBI	AUM		TOSE	594	INE	W	164	DRIDGE
	2	FAMILY	Print) Pt	ECORD,	5 191	SAY	DDAESS (Str	AS	ber or Rural	Poute Num	niber, City or fow	n, State, Zip	Code)	
e 6 ma ector, 1		20a. METHOD OF DISPOSITION 1 Burial 2 Cremation : 4 Donation 8 Other (Spe		val from State	20b. PLACE	AND DATE OF		(Name of	7.	0A1	8 PA	CATION - 1	City or Town	, Stata MD,
ALTIM death. Page tuneral direction		21. SIGNATURE OF FUNERAL SE	ERVICE LIC	ENGEE .	61C.7	#	22. HAM	E AND ADDI	HESS OF PA	CILITY	201	14	400	2
0 75		Pher	20	- Yar	m006	77	3	880	1	126	125	20	PAR	EXVILLE
in 24 hours ely filled in t nation, or re-		INMEDIATE CAUSE (Finel disease or condition resulting in death)	bea, or c fellure, i	. CAF	ise on each line $RDIOPUL$	MONA	RY AI			th aa car	diac or resp	ratory arm	eat,	Approximata Interval Between Onset and Death
D 0 1 8			_		OR AS A CONSEC $EBROVA$			TOTO	1 37 CD					
5 70 - 6	RTIFICATION	Sequentially list conditions if any, leading to immediate			(OR AS A CONSEC			LIDE	IV T					
00 # F	<u>S</u>	cause. Enter UNDERLYING CAUSE (Disease or Injury		. REC	TAL CA	NCER								
O die de de	III.	that initiated eventa resulting in death) LAST		OUE TO	(OR AS A CONSEC	DUENCE OF):								
	2 101		0											1
that the by the sand the and the sand t	EDICAL	PART II. Other significent of COLORI		contributing to $L$ $FISTU$		esulting in	the under	ying cause	given in	Part I.	24a. WAS AN PERFOR	MED?	Al C	PERE AUTOPSY FINDINGS WAILABLE PRIOR TO OMPLETION OF CAUSE
111 3 " = 2	5 5 1										1 1 123	- no		F GEATH?
law required as been of Dept. of 23 eb.														
	CIA	25. WAS CASE REFERRED TO ME EXAMINER?	EDICAL	HOSPITAL:		T .		. PLACE OF	DEATH (Ch	eck only o	ne)			
YSICIAN: The law rescribing to Supering the State Dept. of the State Dept. of the State Dept. of the State Dept. of the State Dept. of the State Dept. of the State Dept. of the State Dept. of the State St		1   YES 2   40		1 Impatient 2	ER/Outpatient 3		OTHER:	Home 5 🗆	Rsaldence	8 🗆 Othi	er (Specify)			
日 光 祖 注	ВУ РН	27. MANNER OF DEATH  1 Natural 5 Pend 2 Accident Invest	ding atigation	28a. DATE OF (Month, D		28b. TIME (	ΥΥ	INJURY AT WORK?  YES 2	□ NO	28d. DE	SCRIBE HOW I	NJURY OCC	URED	
ISIO TTENDI TTOR: A affer di	9	3 Suicide 8 Coul	ld not be rmined	28a. PLACE O building,	OF INJURY — At ho	me, farm, str	eet, fectory, o	offics		28f. LOC City	CATION (Street or Town, State)	and Number	or Rural Rou	te Number,
Z Z Z Z	Ā			IAN: To the best of a										nd menner as stated.
TO THE HOSPI TO THE FUNER be filed within	Ü	29b. SIGNATURE AND TITLE OF							CENSE NUI					Ighth, Day, Year)
5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	TO B	30. NAME AND ADDRESS OF PER	RSON WHO	COMPLETED CATE	SE DE DEATH OTE-	4 27) /5 2	riot1	P	2173	0		•	4/5/	93
			HEN	chp.	6701	M- (	MAS	ST.	1	AT	x 40	. 2	120	9
		31. DATE FILED (Month, Day, Year)		0	AR'S SIGNATURE			<del></del>						/
		APR 08 19	993	Julia Da	viden Br	4.00_								
				U										DHMH-18 Bey 1/89



burial-transit permit. Pages 1, 2, 3 should

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 tibuns after death. Place 6 may be retained by the broading or atten	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans be filed within 72 hours after death with the State Dept. of Health and Mental Hydeine prior to burial, cremation, or remonal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
--	---	--

	1 - FOR STATE (	OF MARYLAND /	DEPARTMENT RTIFICATE	OF HEALTH AND	MENTAL HYGIE!		
	1. DECEDENT'S NAME (First, Middle, Last)  Myntle E. Fischen				2. DATE OF DEATH 4-4-/99		3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 2/2-28-8396  1 □ M 23E	6. AGE (in yrs. last	birthday) IF UNDER	1 YEAR IF UNDER 24 HRS. DAYB HOURS MIN.	7. DATE OF BIRTH (Month, Dey, Year) 9-11-190	0.0	IRTHPLACE (State or Foreign puntry) UnyLand
TOR	ea. FACILITY NAME (If not institution, give street and number Dulancy Towson Nur RESIDENCE OF DECEDENT	er)		TOWN OR LOCATION OF		9c. COUNTY	
DIRECTOR	Md. 10b. COUNTY		Bal	timo ne			10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 2922 Harview Ave.			10f. ZIP CODE 2/23	4	U.S.	A .
ВХ	1 Never Married 2 Married FORCES	EDENT EVER IN U.S. ARM 1 YES 2 X NO HIVE WAR OR DATES		WAS DECENDENT OF HISP If yes, specify Cuben, Mexi 1 YES 2 X10 Spec	can, Puerto Rican, etc.)		TACE — American Indian, Black, White, atc. Specify: White
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4)	(Giv	EDENT'S USUAL OG Be kind of work done of DO NOT use retired.) MEMARE	during most of working	16b. KIND OF BU	siness/inoustr	ry .
OM	17. FATHER'S NAME (First, Middle, Lest)			16. MOTHER'S N	AME (First, Middle, Maider		
BE C	Joseph Richards			13	izabeth B	ouldin	
5	19a. INFORMANT'S NAME (Type/Print)	19b.	MAILING ADDRESS	S (Street and Number or Rura	Route Number, City or Toy	m, State, Zip Code	)
Ì	Mrs. Nancy K. Marsh		3/8 KLA	Llonan Rd	Dalto.,	Md. 2	7/093
	1 XBurial 2 Cremation 3 Ramoval from Star 4 Donation 5 Other (Specify)	gemetery, crem	atory or other place)	norial Cen	2.4/8 B	a/to	M.d
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22.	NAME AND ADDRESS OF	ACILITY	/ //	0
	Gody o Smith	_	7	7527 Harlo	rd Rd. B	eraz n alto	Ome Md.21234
	23. PART   Entar the diseases, or complication ahock, or heart failure. List only one	that caused the daa cause on each line.	th. Do not entar	the mode of dying, su	ch as cardiac or resp	iratory arrest,	Approximate interval Between
	IMMEDIATE CAUSE (Finel	E TO (OR AS A CONSECU	JENCE OFI:				Onset and Death
TION	Sequentially list conditions, if any, leading to immediate	E TO (OR AS A CONSEQU					
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	E TO (OR AS A CONSEOL	JENCE OF):				
AL CE	PART II. Other algnificant conditions contributing	g to death but not re-	aulting in the up	derlying cause given i	Part I. 24a, WAS AN	aurmoney T	24b. WERE AUTOPSY FINDINGS
PHYSICIAN: MEDICA				acrying course gireii ii	PERFOI	MEO?	AMRLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
Ä							
SC.	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 NO 1 popular		QTHER	26. PLACE OF OEATH (C			
H	27. MANNER OF DEATH 26s. OAT		26b. TIME OF	ing Home 5 - Residence 28c. INJURY AT	6 Other (Specify) 28d. DESCRIBE HOW	NJURY OCCURE	<del></del>
ВУР	1 Netural 5 Pending 2 Accident Investigation	nth, Day, Year)	INJURY M	WORK?			
	3 Suicide 26s. PLA	CE OF INJURY — At hom ding, atc. (Specify)	e, farm, street, facto	ory, offica	26t. LOCATION (Street City or Town, State)	and Number or Ru	ral Route Number,
	4 Homicide determined						
COMPLETE							te(a) and menner as stated.
BE COMPLETED	4 Homicide detarmined  29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the be			pinion, death occured at the 29c. LICENSE NU	e time, data and place, ar	d due to the cau	AED (Month, Day, Year)
шШ	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis	of axamination and/or im	veatigation, in my o	pinion, death occured at th	e time, data and place, ar	d due to the cau	
BE	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the beautions) 2 MEDICAL EXAMINER: On the beautions of the complete of t	CAUSE OF DEATH (ITEM	27) (Type, Print)  Nov+	pinion, death occured at the 29c. LICENSE NU	e time, data and place, and MBER	29d. DATE SIGN	4ED (Month, Day, Year)



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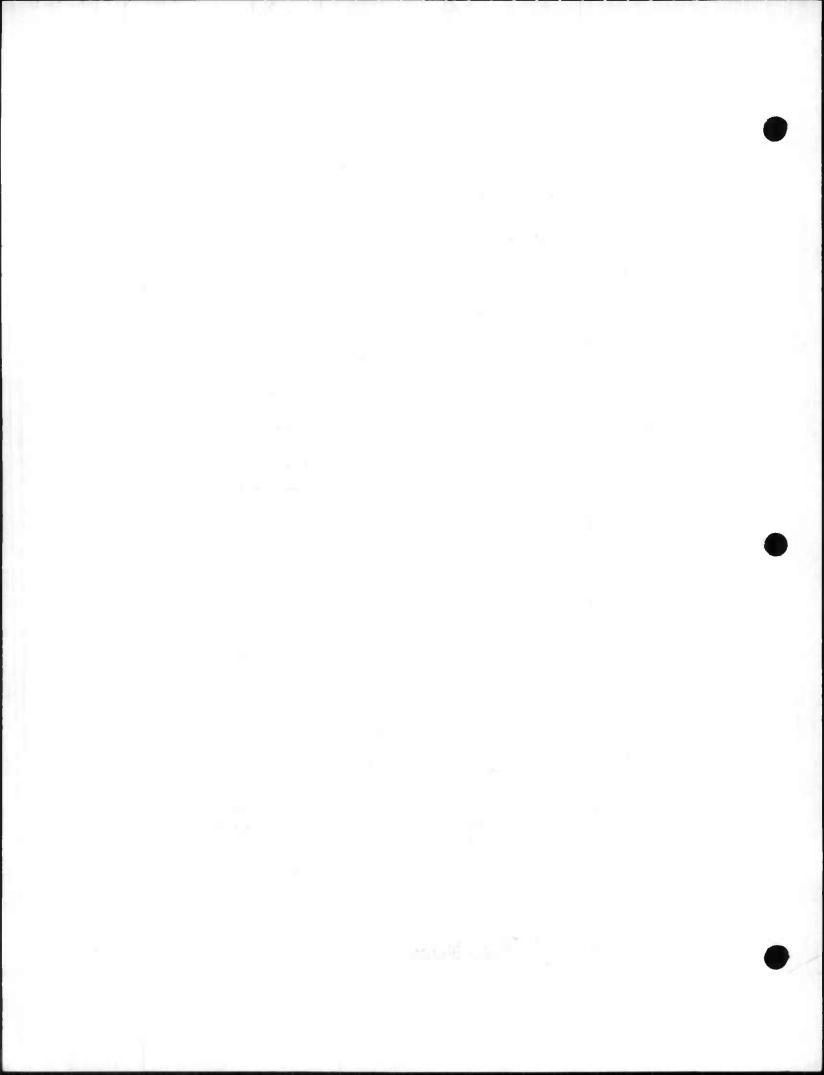
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIFNE

	1. DECEDENT'S NAME (First, Middle, Last)											
- 4								2. DATE O	F DEATH	AY	YEAR	3. TIME OF DEATH
	John	H. Fox	(					4	6			6:35 A.I
	4. SOCIAL SECURITY NUMBER 215-09-6634	1 Man Oc	AGE (In yrs. le	est birthday) YRS.	MONTHS DAY		24 HRS. MIN.	7. DATE OF (Month, 2 - 26	Day, Year)		Country)	lace (State or Fore
1	9a. FACILITY NAME (If not institution, give		00		9b. CITY, TOV	VN OR LOCATIO	N OF DE			9c. COUNT		
DINECTOR	Bel Air Convales	scent Cente	er		Bel	Air				Harf	ord	
2	10e. STATE 10b. COUNT	ry		10c. CIT	Y, TOWN OR LO	CATION						10d. INSIDE CITY
	Maryland Bal	ltimore			Towson							1 TES 2 K
FUNERAL	404 Dixie Dr.					21204				U.S		HAT COUNTRY?
n	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EN FORCES? 1 SIF YES, GIVE WAR	YES 2 OR DATES	RMED NO	If yes	DECENDENT O , specify Cuba YES 2 X NO	, Mexican	, Puerto Ric			4. RACE Black, Specify Whit	
3	15. DECEDENT'S ED (Specify only highest grad			Give kind of	USUAL OCCUP	ATION	7	16b. K	UND OF BUS	SINESS/INDU		
COMPLE	Elementary/Secondary (0-12)	College (1-4 or 5+) 4 yrs	111	e. Do NOT u	Manage		•	S	.B.A.	-U.S.	GOV	ernment
3	17. FATHER'S NAME (First, Middle, Last)							IE (First, Mic	ddle, Maiden			
BE	John H. Fox						jore		Smi			
2	19a. INFORMANT'S NAME (Type/Print)  Deborah Lee Tomne	277			ixie D						Code)	
	20s. METHOD OF DISPOSITION	-	-	_	OF DISPOSITION		3011,	DATE	_	CATION — CI	ty or To-	n State
1	1 Buriel 2 M Cremetion 3 Re- 4 Donation 5 Other (Specify)	noval from State	cemetery, cr	rematory or o				4-8		vson,		,
	21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE		/	22. NAM	E AND ADDRES	S OF FAC	ILITY				
	1		A		Ruc	k Tows O York	on F	unera	1 Hon	ne, In	204	
	immediate Cause (Final disease or condition resulting in death)	List only one cause  Sever	on each lin	Coi	not antar the							Approximatinterval Bet Onset and
ATION	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. Tobacc	AS A CONSE	COPEOUENCE OF	not antar the							Interval Bel
ERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions,	a. Due to (on Due to (on c.	AS A CONSE	EQUENCE O	not antar the						et,	Interval Bel Onset and
N: MEDICAL CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	a. DUE TO (OR DUE TO (OR DUE TO (OR d.	R AS A CONSE	EQUENCE O	not antar the	mode of dyl	ng, such	Part I. 2		AUTOPSY MED?	24b. )	Interval Bel Onset and
MEDICAL	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other algnificent conditions are conditions.	a. DUE TO (OR DUE TO (OR DUE TO (OR d.	R AS A CONSE	EQUENCE O	In the underl	mode of dyl	ng, such	Part I. 2	ec or reaple	AUTOPSY MED?	24b. )	Interval Bei Onset and 20 yr 40 yr WERE AUTOPSY FIN MARIABLE PRIOR TI COMPLETION OF CA OF DEATH?
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PHYSICIAN: MEDICAL	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other algnificent conditions are conditions.	a. DUE TO (OR DUE TO (OR d. DUE TO (OR d. HOSPITAL:	on each ling.  R AS A CONSE  R AS A CONSE  R AS A CONSE  R AS A CONSE  RAS A CONSE	EQUENCE O	OTHER: 4) Nursing I ale OF 28c.	mode of dyl	lven in F	Part I. 2	PERFOR	AUTOPSY MED?	24b. )	Interval Bei Onset and 20 yr 40 yr WERE AUTOPSY FIN MARIABLE PRIOR TI COMPLETION OF CA OF DEATH?
ED BY PHYSICIAN: MEDICAL	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other algnificent conditions are conditions. If the conditions is a sequence of the conditions are conditions. If the conditions is a sequence of the conditions is a sequence of the conditions are conditions. If the conditions is a sequence of the conditions is a sequence of the conditions is a sequence of the conditions is a sequence of the conditions in the cond	a. DUE TO (OR DUE TO (OR DUE TO (OR DUE TO (OR d. DUE TO (OR d. DUE TO (OR d. DUE TO (OR	on each ling on each ling of the state of th	EQUENCE O	OTHER: 4) Nursing I	ying cause g  PLACE OF DI  Home 5 Re  INJURY AT  WORK?  YES 2	lven in F	Part I. 2  ck only one)  G Other ( 28d. DESC)	R4a. WAS AN PERFOR	AUTOPSY MED?  NJURY OCCU	24b. 1	Interval Bei Onset and  20 yr  40 yr  WERE AUTOPSY FIN MARIABLE PRIOR TI TOMPLETION OF CA OF DEATH?
ED BY PHYSICIAN: MEDICAL	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other algnificent conditions and the conditions of t	a. DUE TO (OR DUE TO (	on each lin	EOUENCE O  COUENCE O	QTHER: 4 Mursing I ME OF JURY M 1 street, factory, or	ying ceuse g  i. PLACE OF DI  Home 5	Iven In F	Part I. 2  ck only one)  Glober ( 28d. DESCI	PERFORM IN TOWN, State)  ION (Street a Town, State)	AUTOPSY MED?  NJURY OCCU	24b. \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\	Interval Bei Onset and  20 42  40 4  WERE AUTOPSY FIN MAILABLE PRIOR TO COMPLETION OF CA OF DEATH?  1 YES 2 No.
BE COMPLETED BY PHYSICIAN: MEDICAL	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other algnificent conditions and the conditions of t	a. DUE TO (OR b. DUE TO (OR c. DUE TO (OR d. DUE TO (OR d. DUE TO (OR d. DUE TO (OR d. DUE TO (OR d. DUE TO (OR d. DUE TO (OR d. DATE OF IN) 26a. DATE OF IN) 26b. PLACE OF IN building, etc.	on each lin	EOUENCE O  COUENCE O	QTHER: 4 Mursing I ME OF JURY M 1 street, factory, or	ying ceuse g  B. PLACE OF DI  Home 5 Re  INJURY AT  WORK?  YES 2  office  dete and place,  n, death occur	Iven In F	Part I. 2  Ck only one)  G Other ( 28d. DESC  28t. LOCAT  City or	PERFORM IN TOWN, State)  ION (Street a Town, State)	AUTOPSY IMED?  NJURY OCCU	24b. 1	Interval Bei Onset and  20 42  40 4  WERE AUTOPSY FIN MAILABLE PRIOR TO COMPLETION OF CA OF DEATH?  1 YES 2 No.
COMPLETED BY PHYSICIAN: MEDICAL	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST  PART II. Other algnificent conditions and the conditions of t	a. DUE TO (OR DUE TO (OR DUE TO (OR C. DUE TO (OR d. DUE TO (OR d. DUE TO (OR d. DUE TO (OR DUE TO	on each ling.  R AS A CONSE  R	EQUENCE O  EQUENCE O  FOUENCE O  TOURNE OF THE IN.	OF):  In the underly a street, factory, on, in my opinion of the underly at the time, on, in my opinion on, in my opinion on the underly at the time, on, in my opinion on the underly at the time, on, in my opinion on the underly at the time, on, in my opinion on the underly at the time, on, in my opinion on the underly at the time, on, in my opinion on the underly at the time, on, in my opinion on the underly at the time, on, in my opinion on the underly at the time, on, in my opinion on the underly at the time, on, in my opinion on the underly at the und	ying ceuse g  B. PLACE OF DI  Home 5 Re  INJURY AT  WORK?  YES 2  office  dete and place,  n, death occur	EATH (Chesidence 6	Part I. 2  Ck only one)  G Other ( 28d. DESC)  28t. LOCAT  City or	PERFORM IN TOWN, State)  ION (Street a Town, State)	AUTOPSY IMED?  NJURY OCCU	24b. 1	Interval Bei Onset and  20 yr  40 yr  WERE AUTOPSY FIN MARIABLE PROP OF CA DE DEATH?  I VES 2 No

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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,



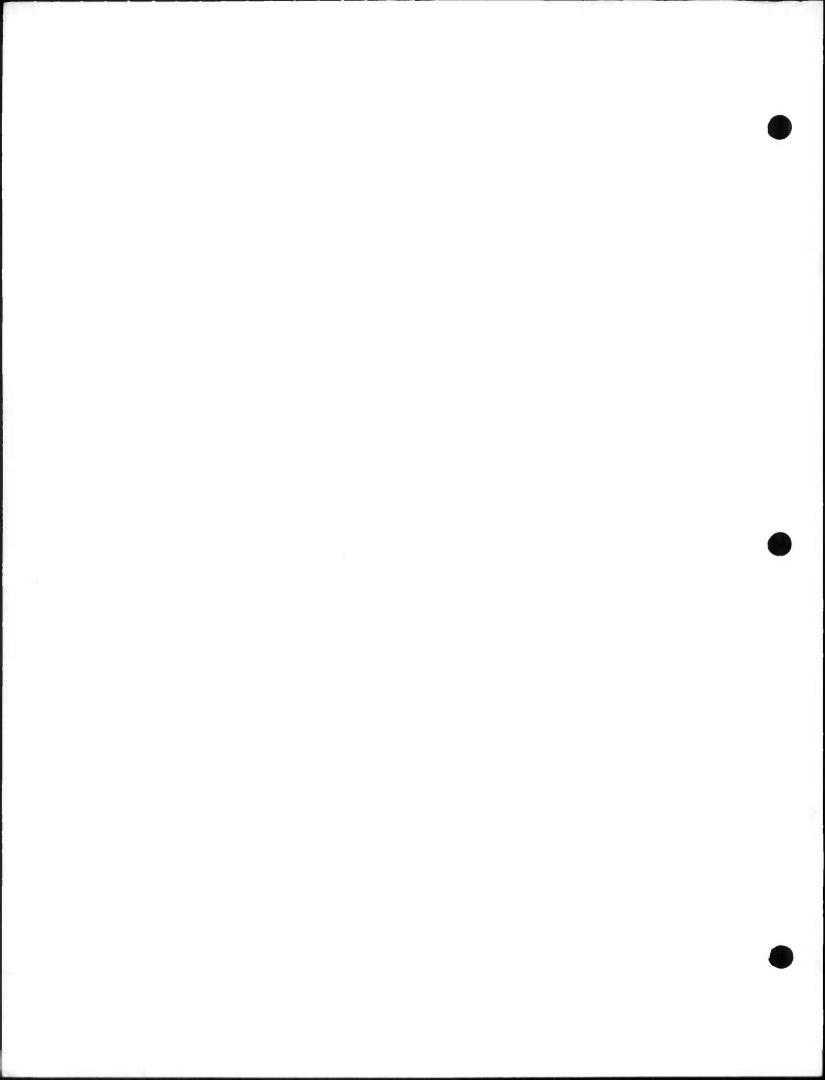
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	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTI	MENT OF HEALTH AND CATE OF DEATH	MENTAL HYGIENE REG. NO.					
	1. DECEDENT'S NAME (First, Middle, Last)	44			2. DATE OF DEATH	3. TIME OF DEATH				
	MARY GEISENDA			sendaffer	MONTH, 5 DAY	93" 7 -A "				
	4. SOCIAL SECURITY NUMBER	——————————————————————————————————————	7	F UNDER 1 YEAR IF UNDER 24 HRS	CAR	8. BIRTHPLACE (State or Foreign Country)				
	215-09-5758	1 M 2 X F	YRS.		02 09 16	Md.				
œ	99. FACILITY NAME (If not institution, give st CHURCH HOSPITA			BALT IMORE		OUNTY OF DEATH				
OT	RESIDENCE OF DECEDENT		LOIV	DALITHORE	CIII					
DIRECTOR	10a. STATE 10b. COUNTY  Moda Bala			TOWN OR LOCATION		10d. INSIDE CITY LIMITS?				
	100, STREET AND NUMBER	timore		astwood		1 YES 2 X NO				
FUNERAL	421 Pembrooke Bu	lvd.		2/224	10g. C	U.S.A.				
Į.	11. MARITAL STATUS  1 Never Married 2 Merried	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DECENDENT OF HISI If yes, specify Cuben, Mex	PANIC ORIGIN? (Specify Yes or No-	- 14. RACE — American Indian, Black, While, etc.				
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	res		ocity:	Specify: White				
	15. DECEDENT'S EDUC	CATION	16a. DECEDENT'S US		16b. KIND OF BUSINESS/					
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use i	The state of the s						
MP	12		How	ewrk	At Hon	ne				
	17. FATHER'S NAME (First, Middle, Last)	Sloan		18. MOTHER'S	NAME (First, Middle, Melden Surname	)				
BE	19a. INFORMANT'S NAME (Type/Print)	JADOIL	10h MAII INC AI	DOSE Comment of Number of De-	al Route Number, City or Town, State,					
2	Jack Geis				ace Miami, Fl. 3					
	209. METHOD OF DISPOSITION	20b.	PLACEANDDATEOF	DISPOSITION (Name of	DATE 20c LOCATION	— City or Town, State				
	1 % Buriel 2 Cremation 3 Remo	oval from State certa	tery cramatogy of othe	s Mem. Garden	s 4-9-98 Midd	le River, Md.				
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		22. NAME AND ADDRESS OF	FACILITY	( 1				
	(Kale)	D. Jules		(harles S. Le	iler & Son Inc.	Eastern Ave.				
	23. PART I. Enter the diseasea, or c	omplications that caused List only one cause on ee	the death. Do not	enter the mode of dying, a	uch as cardiac or respiretory	Approximate Interval Between				
	IMMEDIATE CAUSE (Finel			1 /0						
	IMMEDIATE CAUSE (Finel disease or condition resulting in death)  DEMENTIA, 2 Myoc. INF. WKS.  DUE TO (OR AS A CONSEQUENCE OF):									
	DUE TO (OR AS A CONSEQUENCE OF):									
ĕ	Sequentielly list conditions, if any, leading to immediate	OUE TO (OR AS A	CONSEQUENCE OF):							
S	cause. Enter UNDERLYING CAUSE (Disesse or injury	2								
	that initiated events resulting in death) LAST	OUE TO (OR AS A	CONSEQUENCE OF):							
CERTIFICATION	resulting in deetily EAST	1								
AL	PART II. Other aignificant conditions	s contributing to death bu				Y 24b. WERE AUTOPSY FINDINGS				
2	061	MYOCA	a. In	PARCO	1   YES 2/2 NO	COMPLETION OF CAUSE OF DEATH?				
ME	CA.BA	RAST!				1 TES 2 NO				
Ä	UTI									
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		28. PLACE OF DEATH (	Check only one)					
1YS	1 VES 2 NO	1 Inpatient 2 ER/Outpe	tient 3 DOA 4	Nursing Home 5 Residence						
	1 Natural 5 Pending	(Month, Day, Year)	INJUR	PF 28c. INJURY AT WORK?  M 1 YES 2 NO	28d. OEŞCRIBE HOW INJURY (	OCCURED				
ВУ	2 Accident Investigation 3 Suicide 8 Could not be	280. PLACE OF INJURY	At home, ferm, stre		281. LOCATION (Street and Numi	ber or Rural Route Number,				
ij	4 Homicide determined	building, etc. (Specif	γ)		City or Town, Stete)					
COMPLETED	29e. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of my knowle	dge, death occurred	at the time, date end place, and d	ue to the cause(s) end menner es a	rieted.				
OM						the ceuse(s) end menner es stated.				
BE C	296. SIGNATURE AND TITLE OF CERTIFIER	l)		IN LICENSE N	IUMBER 29d. D	ATE SIGNED (Month, Day, Year)				
TO B	A-1-No	remi'	no	017	322 1.	4/5/93				
	36. NAME AND ADDRESS OF PERSON WHO			011011011	SPITAL CORPO					
	DR. ATAOLLAH N 31. DATE FILED (Month, Day, Year)	IAZEMI, M.D.		N. BROADWAY	BALTIMORE,	MARYLAND 2123L				
1	APR 08 1993	lia Davidson-Rand	ell							
II.	ININ TO TOOL /									

X . 2 7 3 X . . . gar a second a second

BALTIMORE, MARYLAND 21215-0020	ours after death. Page 6 may be retained by the hospital or attending physician. In in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should by remone.	nedical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNREDNA After this certificate has been signed by the attending physician and completely fifted in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State beat of Health Advental Hoviene prior to burial creatation or remove.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE OF	MARYLA		TMENT OF H		ENTAL HYGIENI REG. NO.		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
	1. DECEDENT'S NAME (First, Middle, Last)	-				2. DATE OF DEATH DA	Y YE	3. TIME OF DEATH
	JANE GODWIN		ane K.	Godwin		4 7	9	3 5:15 Am
1			yrs. last birthday)	MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)
	9a. FACILITY NAME (If not institution, give street and number)		76 THS.	AL OUTY TOWN		Aug 28 1		Maryland
DIRECTOR	STELLA MARIS RESIDENCE OF DECEDENT	H09	PICE		SON, M	try/AND	ec. COUNTY	timore
1 2	10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCAT	ION			10d. INSIDE CITY
	Maryland Harford 100. STREET AND NUMBER				rdeen			LIMITS?  1 YES 2 NO  OF WHAT COUNTRY?
FUNERAL	3016 Creswel				21	001	Unite	ed States
5	11. MARITAL STATUS  1 Never Married 2 Married FORCES?	1 TYES	U.S. ARMED 2 XNO	13. WAS DEC	ENDENT OF HISPANIC	ORIGIN? (Specify Yes Puerto Rican, etc.)	or No 14.	RACE - American Indian, Black, White, etc.
B≺	3 Wildowed 4 Divorced IF YES, GIV	WAR OR DAT	TES	1 - YES	2 NO Specify:			Specify: White
8	15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S	USUAL OCCUPATION	W .	16b. KIND OF BUS	INESS/INDUST	
	Elementary/Secondary (0-12) College (1-4 or	5+)	(Give kind of life. Do NOT u	work done during mo se retired.)	st of working			
COMPLETED	122		Secre	etary		State	e Mary	land
8	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME	E (First, Middle, Maiden :	Sumame)	
R	John F. Thomas Sr.  190. INFORMANT'S NAME (Type/Print)					lary J. Por		
2	Thomas G. Godwin Jr.		4			ute Number, City or Town		
	20a. METHOD OF DISPOSITION			OF DISPOSITION (Na		berdeen, M		1001
	1 🂢 Burlat 2 🗆 Cremation 3 🗆 Removal from State 4 🗆 Donation 5 🗀 Other (Specify)	Pa	tery, cremetory or o	ther plece) Cemetery	4/10/9	1	timore	a company of the comp
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE MILT	n J kn	ight Jr	22. NAME AN	D ADDRESS OF FACIL	Balti	more, N	Md. 21214
	Metan I Knig	WL.		Leona	rd J. Ruc	k, Inc. 5	305 Har	rford Road
	23. PART I. Enter the diseases or complications shock, or heart fallure. List only one	hat caused	the daath. Do	not antar tha mo	da of dying, auch	aa cardiac or respir	ratory arrest,	Approximate Interval Between
	IMMEDIATE CAUSE (Final			(9100	blasto	ma)		Onset and Daath
NO	Sequentially list conditions,	O (OH AS A (	CONSEQUENCE O	F):				
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	O (OR AS A C	CONSEQUENCE O	F):				
RTIF		OR AS A	CONSEQUENCE O	F):				
8	DADT II Other elemificant conditions contained							
8	PART II. Other algnificant conditions contributing	to death bu	t not reaulting	in the underlying	causa given in Pa	ert I. 24a. WAS AN / PERFORI		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDIC						_ 1 _ YES 2	NO	COMPLETION OF CAUSE OF DEATH?
						-   '		1 TES 2 NO
\¥	25. WAS CASE REFERRED TO MEDICAL			26. PL	ACE OF OEATH (Check	conty one)		
Sic	EXAMINER?  1 YES 2 NO HOSPITAL:  1 Inpetient	☐ ER/Outpat	tlent 3 DOA	OTHER:	5 Residence 8	Other (Specify)	OI/A MA	ris Hospice
PHYSICIAN:	1 Natural 5 Pending	Dey, Year)	28b. TIM	E DF 28c. INJI	JRY AT 2	8d. DESCRIBE HOW IN		
ED BY	Accident Investigation  Suicide 8 Could not be	OF INJURY - g, etc. (Specify	– At home, farm,	street, factory, office		81. LOCATION (Street as City or Town, State)	nd Number or R	tural Route Number,
<u></u>	4 Homicide determined					Oly Or Town, Oldrey		
COMPL	29a. CERTIFIER (Check only one) 2 MEOICAL EXAMINER: On the basis of							use(a) and manner as stated.
H	296. SIGNATURE AND TITLE OF CERTIFIER Cala & Cileta	uda	20		29c. LICENSE NUMBE	87	29d. DATE SIG	PANED (Month, Day, Year)  7193
2	30 NAME AND ADDRESS OF PERSON WHO COMPLETED CO Stella Maris Hos	PICE		o Dulo	neyVal	leyRd	Town	son 21204
		AR'S SIGNAT			7	1,-0		
	APR U8 1993	and the state of the	Panes Me					



1. DECEDENT'S NAME (First, Middle, Last)

ROLLAND

FOR

STATE REGISTRAR

10:00A

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4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) 7. DATE OF BIRTH 77 YRS. 213-07-8101 11 M 2 | F 08-15-1 Virginia permit. Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 301 McMeCHEN STREET DIRECTOR #1121 Baltimore city RESIDENCE OF DECEDENT 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Baltimore City MD. 1 1 YES 2 | NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21217 301 McMechen Street use as the bunial-transit U.S. 24 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuben, Mexican, Puerto Ric 1 ☐ YES 2 😭 NO Specify: BY 3- Widowed 4 Divorced Black Army COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest Elementary/Secondary (0-12) 7th Por College (1-4 or 5+) Retired Warehouse Man 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname)
Fannie Jefferson Eddie Green page 5 should be notified at BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3910 Loch Raven Blvd. Balto., MD. 2 21218 Marsha Robinson e 20s METHOD OF DISPOSITION
1 Burlel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20b. PLACE AND DATE OF DISPOSITION (Name of Certair or Hard) A Certair or Hard Country of Town, State Certair or Hard Certair director, p must examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY and completely filled in by the funeral pund, cremation, or removal. 1721-27 N.Monroe ST. E.L.Phillips F/H #281 retho Balto., MD. 21217 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximata shock, or hasrt failure. List only one cause on each line. interval Batween **IMMEDIATE CAUSE (Final** Onset and Daeth the disease or condition GUNSHOT WOUND OF HEAD within resulting in death) traumatic event, OUE TO (OR AS A CONSEQUENCE OF): executed CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to if sny, leading to immediate cause. Enter UNDERLYING has been signed by the attending physician Dept. of Health and Mental Hygiene prior to CAUSE (Disease or Injury that initiated events other DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST 6 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE shows any 1X YES 2 NO OF DEATH? UNIOU 1 X YES 2 - NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF OEATH (Check only one) THE HOSPITAL OR ATTENDING PHYSICIAN: The ITHE FUNERAL DIRECTOR: After this certificate hilled within 72 hours after death with the State I IPORTANT: If Nem 28 Is marked, or Item OTHER: 1 XYES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF INJURY 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation SELF INFLICTED GUNSHOT 1993 9:20A 6 1 YES 2 X NO BY 2 Accident
3 Suicide 28e. PLACE OF INJURY - At home, ferm, atreet, factory, office 281. LOCATION (Street and Number or Rural Route Number City or Town, State) 6 Could not be BEDROOM-301 MCMECHEN STREET 4 Homicide determined BALTIMORE CITY COMPLET 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date end piece, end due to the cause(s) end manner es atated. TO THE HOSPITA
TO THE FUNERAL
DE filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(s) end manner es stated. BE 29c. LICENSE NUMBER 29d. OATE SIGNED (Month, Day, Year) OCME 1993 **4** 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JWM 111 Penn Street, Baltimore, Maryland 21201 DHMH-18 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

GREEN

2. DATE OF DEATH

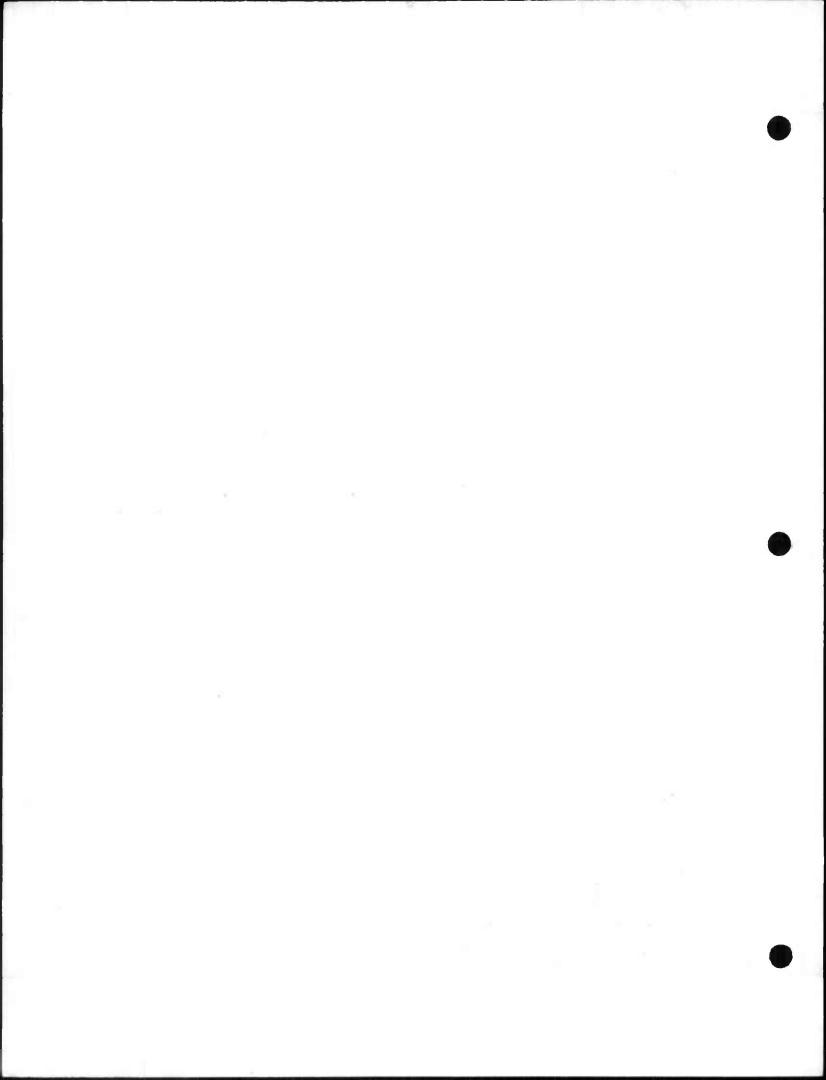
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Heatth and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

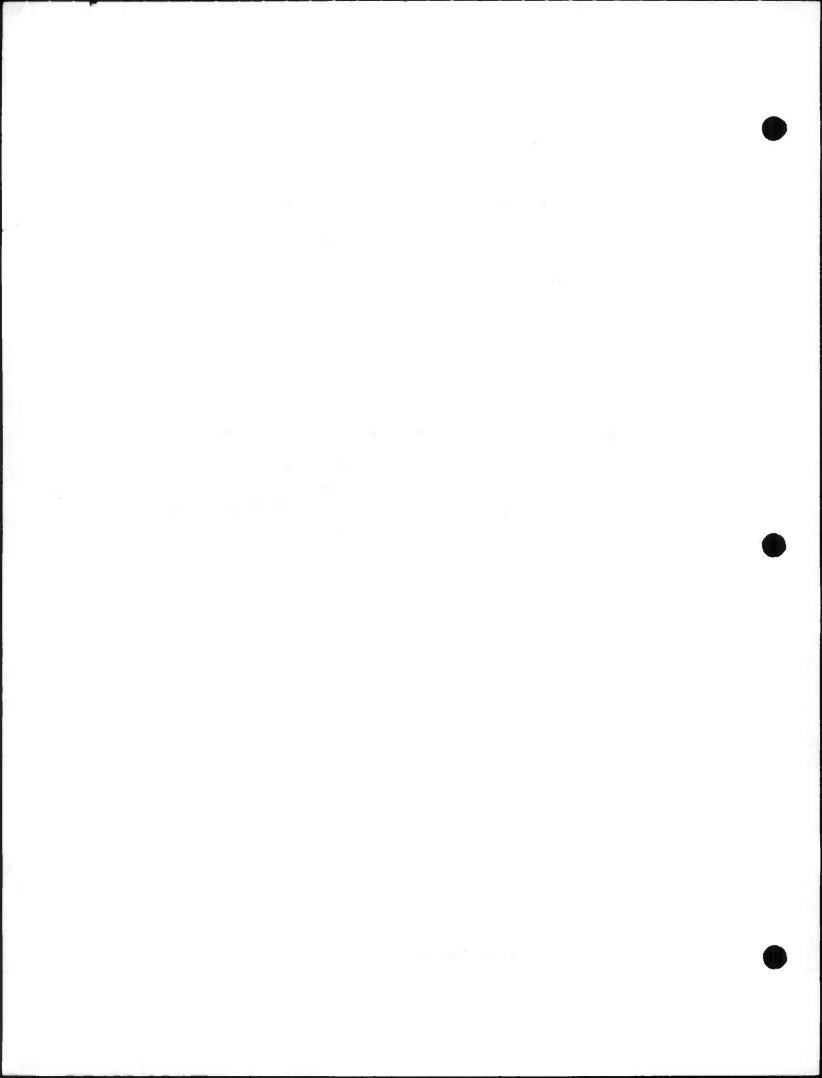
	1 - STATE REGISTRAR		ARYLAND C	ERTIF	CATE	OF	DEATH	MENIA	REG. NO.	E		
1	1. DECEDENT'S NAME (First, Middle, Last)					-			E OF DEATH			3. TIME OF DEATH
l i	ALBERT	CHADWI	CV			CAL	RANT	MON		199	YEAR C 2	4:30 P.M
	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. Is	st birthday)	IF UNDER		IF UNDER 24 HRS.		E OF BIRTH	3. 7.		IPLACE (State or Foreign
	385-86-2296	1 ☑ M 2 ☐ F	23	YRS.	MONTHS	DAYS	HOURS MIN.	(Mor	ith, Day, Year)	_	Countr	γ)
	9a. FACILITY NAME (If not institution, give st							05	14 6			CHIGAN
m	Sa. PACILITY NAME (If not institution, give st	treet and number)			9b. CITY,	TOWN C	R LOCATION OF I	DEATH		9c. COUN	ITY OF D	EATH
DIRECTOR	Jackson Pond Long Reach Howard								3			
DIRE	MARYLAND 10b. COUNTY				10c. CITY, TOWN OR LOCATION COLUMBIA							10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 5436 NEWGRA	———— H	101. ZIP CODE 21045				 5				VHAT COUNTRY?	
Z	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. A									
	1 Never Married 2 Married	FORCES? 1	YES 2	NO If yes, specify Cuban, Maxican					Rican, etc.)	or No-	14. RACE Black	E — American Indian, r, White, etc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WA	R OR DATES		1	☐ YES	2X NO Spec	ity:			Speci	•
60	15. DECEDENT'S EDUC	2471011			1							WHITE
	(Specify only highest grade	completed)		ECEOENT'S I	ork done o	CUPATIO	N I of working	16	b. KIND OF BUS	INESS/IND	USTRY	
COMPLET	Elementary/Secondary (0-12) 12TH	College (1-4 or 5+)		ALESM								
ő	17. FATNER'S NAME (First, Middle, Last)						18. MOTNER'S N	AME (First.	Middle, Maiden	Sumame)		
Ш	ALBERT RI	CHARD GAI	RANT				DON	INA B	RANCH	,		
00	19a. INFORMANT'S NAME (Type/Print)			DE MAILING	AODRECC	(Camera o	nd Number or Rura					
2	ALBERT RICHARD O	ידיזא א ס א י	"									
.		MANI					GE GARTH	I, CO	TOWRIA	, MAR	YLAN	ND 21045
	20a. METHOD OF DISPOSITION 1 □ Burlai 2 ☒ Cremation 3 ☒ Ramo	oval from State		AND DATE O		TION (Na	ne of	/ OA	TE 20c. LO	CATION —	Ity or To	wn, Stata
	4 Donation 5 Other (Specify)			meRe		?em	story 4	1819	3 1)	TRO	iT,	Michigan
	21. SIGNATURE OF FUNERAL SERVICE LIC		40	1			D ADDRESS OF F					
	· a ala	n De	14 1	4			AN SEIT					
-			7.7	(	3	818	ROLAND	AVEN	UE, BAI	LTO.	MD.	21211
	23. PART I. Enter the diseases, or c shock, or heart fellure. I IMMEDIATE CAUSE (Final	Liet only one caus	e on eech lin	eath. Do n	ot enter	the mod	ie of dying, su	ch as cs	diec or reapi	retory sm	est,	Approximate Interval Between Onset and Death
		DROWN				TIN	G SEI	ZUR	E DIS	ORV	ER	
	DUE TO (OR AS A CONSEQUENCE OF):											
ŏ i	Sequentially list conditions,	DUE TO (	OR AS A CONSE	OHENCE OF	1.							
夏月	If any, leading to immediate cause. Enter UNDERLYING	302 10 (0	//	QUENCE OF	1:							i
- Q												
2	CAUSE (Disease or Injury	C. DUE TO (										<u> </u>
TIFICA	CAUSE (Disease or Injury that initiated events	DUE TO (C	OR AS A CONSE	QUENCE OF	):							
ERTIFICA	CAUSE (Disease or Injury	DUE TO (C	OR AS A CONSE	QUENCE OF	):							
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in deeth) LAST	d						01				
ا پر	CAUSE (Disease or Injury that initiated events	d				derlyling	cause given in	Part I.	24a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS
ا پر	CAUSE (Disease or Injury that initiated events resulting in deeth) LAST	d				derlying	cause given in	Part I.		MED?	24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE
ا پر	CAUSE (Disease or Injury that initiated events resulting in deeth) LAST	d				derlylng	cause given in	Part I.	PERFOR	MED?	24b.	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ا پر	CAUSE (Disease or Injury that initiated events resulting in deeth) LAST	d				derlying	cause given in	Part I.	PERFOR	MED?	24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE
ا پر	CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART II. Other algnificant conditions  25. WAS CASE REFERRED TO MEDICAL	d							PERFOR	MED?	24b.	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ا پر	CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART II. Other algnificant conditions  25. WAS CASE REFERRED TO MEDICAL EXAMINER?	a contributing to d	leeth but not	resulting is	othen	26. PL.	ACE OF DEATH (C	heck only a	PERFOR 1 YES 2	MED?	24b.	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ا پر	CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART II. Other algnificant conditions  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 🖾 YES 2 🗆 NO	a contributing to d	leeth but not	resulting is	OTHER	26. PL	ACE OF DEATN (C	heck only o	PERFOR  1 YES 2  ne)  or (Specify)	MED? □ NO  P(	ond	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART II. Other algnificant conditions  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 🖄 YES 2 🗆 NO  27. MANNER OF DEATH	a contributing to d	leeth but not	resulting is	OTHER	26. PL.	ACE OF DEATN (C	heck only o	PERFOR  1 YES 2  Per (Specify)  SCRIBE HOW IF	P(	ond	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST  PART II. Other algnificant conditions  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 X YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending	a contributing to d	leeth but not	resulting is	OTHER	26. PL.: ing Home 28c. INJU WOI	ACE OF DEATN (C	heck only o	PERFOR  1 YES 2  ne)  or (Specify)	MED? □ NO  P(	ond	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART II. Other algnificant conditions  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2  NO  27. MANNER OF DEATH  1  Netural 5  Pending Investigation  3  Suicide 8  Could not be	HOSPITAL:  1   Inpetient 2   0  26a. DATE OF II  0 4   Month - Day  26a. PLACE OF	ERVOUIDATION : Send 59U	reculting in	OTHER 4 ONUS OF	26. PL: : ing Home 28c. INJL WOI 1  Y	ACE OF DEATN (C	6 SOth	PERFOR  1 YES 2  1 Specify)  SCRIBE HOW IF  BJECT  SATION (Street in	P(HAD	ond URED I SE	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  ROWNED ANI
BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART II. Other algnificant conditions  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 VES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation	HOSPITAL: 1   Inpetient 2   1 26s. DATE OF II	ER/Oulpetient : NJURY — At ht. (Specify)	reculting in	OTHER 4 ONUS OF	26. PL: : ing Home 28c. INJL WOI 1  Y	ACE OF DEATN (C	6 Yoth 28d. DE SU 28f. LOC	PERFOR  1 YES 2  Per (Specify)  SCRIBE HOW IF	P(  IJURY OCC  HAD	ond URED SE	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  ROWNED AND COURT Number,
BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART II. Other algnificant conditions  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2  NO  27. MANNER OF DEATH  1  Netural 5  Pending Investigation  3  Suicide 8  Could not be determined	HOSPITAL:  1   Inpatient 2   0  26a. DAACE OF Building, at	ER/Outpetient :  NUMY F9U  INJURY — At he to. (Specify)	The state of the s	OTHER 4   Nurs OF   RY 1 5   P	26. PL.: ing Home 28c. INJL WOO 1  Y	ACE OF DEATN (C 5 G Rasidence 17 AT 18K7 ES 2 NO	6 Voth 28d. DE SU 28f. LOC	PERFOR  1 YES 2  PERFOR  1 YES 2  PERFOR  1 YES 2  PERFOR  1 YES 2	PON1	ond SEI Or Rural R	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  ROWNED ANI
BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART II. Other algnificant conditions  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2  NO  27. MANNER OF DEATH  1  Netural 5  Pending Investigation  3  Suicide 8  Could not be detarmined  29s. CERTIFIER (Check only 1  CERTIFYING PNYSIC	HOSPITAL:  1   Inpatient 2   0  26s. DATE OF III  0 4 (Month)  26s. PLACE OF building, st	ER/Oulpetient :  NUMY FQU  INJURY — At he tc. (Specify)	resulting is	OTHER	26. PL.: ing Home 28c. INJL WOI 1  Y	ACE OF DEATN (C	6 SON 28d. DE SU 28f. LOG Ch JA	PERFOR  1 YES 2  Per (Specify)  SCRIBE HOW IF  BJECT  ATION (Street a or Town, State)  CKSON  Used(a) and man	P(NJURY OCC HAD PON)	ond URED SEI Or Rural R D/HC	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  PROWNED AND CO. M. COURT Number, DWARD CO. M.
BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST  PART II. Other algnificant conditions  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation investigation investigation determined  29. CERTIFIER (Check only one)  21. MEDICAL EXAMINER?	HOSPITAL:  1   Inpatient 2   0  26s. DATE OF III  0 4 (Month)  26s. PLACE OF building, st	ER/Oulpetient :  NUMY FQU  INJURY — At he tc. (Specify)	resulting is	OTHER	26. PL.: ing Home 28c. INJL WOI 1  Y	ACE OF DEATN (C	6 SON 28d. DE SU 28f. LOG Ch JA	PERFOR  1 YES 2  Per (Specify)  SCRIBE HOW IF  BJECT  ATION (Street a or Town, State)  CKSON  Used(a) and man	P(NJURY OCC HAD PON)	ond URED SEI Or Rural R D/HC	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  PROWNED AND CO. M. COURT Number, DWARD CO. M.
COMPLETED BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART II. Other algnificant conditions  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2  NO  27. MANNER OF DEATH  1  Netural 5  Pending Investigation  3  Suicide 8  Could not be detarmined  29s. CERTIFIER (Check only 1  CERTIFYING PNYSIC	HOSPITAL:  1   Inpatient 2   0  26s. DATE OF III  0 4 (Month)  26s. PLACE OF building, st	ER/Oulpetient :  NUMY FQU  INJURY — At he tc. (Specify)	resulting is	OTHER	26. PL.: ing Home 28c. INJL WOI 1  Y	ACE OF DEATN (C	6 Coth 28d, DE SU 28f, LO C/f) JA a to the ca	PERFOR  1 YES 2  Per (Specify)  SCRIBE HOW IF  BJECT  ATION (Street a or Town, State)  CKSON  Used(a) and man	P(NJURY OCC HAD PON)	ond URED SE: or Rural R D/H Od.	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  PROWNED AND CO. M. COURT Number, DWARD CO. M.
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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1.2 should
be filed within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL		ENT OF HEALTH AND	MENTAL HYGIEN	E							
J.	1. DECEDENT'S NAME (First, Middle, Last)	-			2. DATE OF DEATN		3. TIME OF DEATN						
10	OTIS J		GIBBS		MONTH DA	9 2							
				INDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTN	-	TTHPLACE (State or Foreign						
×	263-20-9333		87 YRS. MON		(Month, Day, Year)	Coc	intry)						
	9a. FACILITY NAME (If not institution, give stre			CITY, TOWN OR LOCATION OF D	2/22/190								
DIRECTOR	UNION MEMORIAL HO			ALTIMORE CITY	EATH	9c. COUNTY OF	DEATN						
5	RESIDENCE OF DECEDENT												
H	10e. STATE 10b. COUNTY		10c. CITY, TO	WN OR LOCATION			10d. INSIDE CITY LIMITS?						
□	MARYLAND		BA	LTIMORE			TY YES 2 NO						
FUNERAL	10e. STREET AND NUMBER			101. ZIP CODE		10g. CITIZEN O	F WHAT COUNTRY?						
ER	4735 WRENWOOD	AVENUE		212	12	1	USA						
5		12. WAS DECEDENT EVER II FORCES? 1 YES	N U.S.ARMED	13. WAS DECENDENT OF NISPA			ACE — American Indian,						
		FORCES? 1 YES		It yes, specity Cuban, Maxic	an, Puerto Rican, etc.)	BI	ack, White, etc.						
B	3 XWidowed 4 Divorced		ALES	1 TYES 2X NO Speci	y.	Sp.	Black						
COMPLETED	15. DECEDENT'S EDUCA	TION	16a. DECEDENT'S USU	AL OCCUPATION	16b. KIND OF BUS	INESS/INDUSTRY							
	(Specify only highest grade co	College (1-4 or 5+)	(Give kind of work of the Do NOT use ret	done during most of working med.)									
4													
0	17. FATHER'S NAME (First, Middle, Last)			16 MOTNER'S N	AME (First, Middle, Maiden S	Euroneme)							
		9		10. 110. 110.	C C C C C C C C C C C C C C C C C C C	our remoj							
BE	19a, INFORMANT'S NAME (Type/Print)		19h MAII ING ADD	RESS (Street and Number or Rural	Parish Museline China Survey	One To Out 1							
임	,												
	Fannie Davis 20 METHOD OF DISPOSITION		1 1341 W	. Mosher St									
	1 - Buriel A. Cremetion 3 - Remove	al from State cerr	PLACE AND DATE OF DI netery, cremetory or other p	face)		CATION — City or							
	4 Donation 5 Other (Specify)		aryland N	ational Cem	etery La	urel,	Maryland						
	TOWERAL SERVICE LICE	TORKE	11	22. NAME AND ADDRESS OF FA		Tarrange	DAT HOME						
		1 1 19	11	LEROY O. DY 4600 LIBERT	TIL & DON	LUNEI	TAL HUME						
	23 PART / Enter the diseases, or con	mplications that cause	the death. Do not e	nter the mode of dying, au	ch as cardiac pr reapli	etory arrest.	JE 21207						
	in the state of th												
	disease or condition	Sepa	-				Onset and Death						
	resulting in death) a.		CONSEQUENCE OF):										
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ő	Sequentially list conditions, b.	DUF TO (OR AS (	CONSEQUENCE OF:										
F	if any, leading to immediate cause. Enter UNDERLYING	202 10 (011 10 )	. CONSCOULABLE OF J.				i						
윤	CAUSE (Disease or Injury C.	DUF TO (OR AS (	CONSEQUENCE OF):										
ĒΙ	that initiated events resulting in death) LAST	502 10 (011 110 1	CONSCOUNCE OF J.				i						
CERTIFICATION	d.												
	PART II. Other significant conditions	contributing to death b	ut not reaulting in th	e underlying cause given in	Part I. 24a. WAS AN	UTOPSY 2	4b. WERE AUTOPSY FINDINGS						
2	Pacemak	cen			PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE						
	sick cin		A		1 TYES 2	□ NO	OF DEATH?						
Σ	3,000 5,00	us syn	home				1 TYES 2 NO						
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL												
ਠੁ	EXAMINER?	HOSPITAL:	ОТ	28. PLACE OF DEATN (C)	neck only one)								
YS		I Inpatient 2 ER/Outp		Nursing Nome 5 - Residence	6 Other (Specify)								
표	27. MANNER OF DEATN  1 Matural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE NOW IN	JURY OCCURED							
à	2 Accident Investigation			M 1 YES 2 NO									
60	3 Suicide 6 Could not be	28s. PLACE OF INJURY building, atc. (Spec	— At home, ferm, atreat cify)	tactory, offica	261. LOCATION (Street as City or Town, State)	nd Number or Run	al Route Number,						
<b>"</b>	4 Nomicide determined												
ا ټ	29a. CERTIFIER 1 CERTIFYING PHYSICIA	AN: To the best of my know	ledge, death occurred at	the time, data and place, and du	to the cause(s) and many	ner as stated.							
COMPLET				my opinion, death occured at the			e(s) and manner as stated.						
	29b. SIGNATURE AND TITLE OF CERTIFIER												
w	SEL STATISTIC AND TIME OF CENTIFIER	0-5	dent	29c. LICENSE NU	MBER	29d. DATE SIGN	ED (Month, Day, Year)						
m	C. La. A	1 / A mare 1112 K -	LE JE MINOR	The second secon		- 41							
m	S. Jada					( (	1773						
m	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Print	m PA		. 0-	1 (43						
TO B	S. ZArot, mo	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Print Lew 4 Picco	57 BART.	and 2/2	218	1 (43						
<b>m</b>	0 0 1 1	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Print Lew 4 Picco	57 BALV.	and 2/2	218	/(45						



3. TIME OF DEATH

OHMH-16 Rev 1/89

8. BIRTHPLACE (Stat

A.

REG. NO

2. DATE OF DEATH

7. DATE OF BURTH

ransit permit. Pages 1, 2, 3 should Un. FACILITY NAME (# TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH BY FUNERAL DIRECTOR 10a. STATE 10b. COUNTY 10c/CPTY, TOWN OR LOCATION 10d. INSIDE CITY YES 2 NO 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 212 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Marrie If yes, specify Cuban, Maxican, Puerto R IF YES. GIVE WAR OR DATES NO 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) iours after death. Page 6 may be retained by the hospital filled in by the funeral director, page 5 should be detached ion, or removal. Ó once. 17. FATHER'S NAME (First, Middle, Last) te. MOTHER'S NAME (First, Middle, Majo Re notified at BE 19b. MAILING ADDRESS (Stree 2 pe METHOD OF DISPOSITION DATE 20c. LOCATION must Burial 2 Cremation 3 Donation 5 - Gibel South examiner medical 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximata shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Finel **Onset and Death** the cremation, disesse or condition completely HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within resulting in death) traumatic event, OUE TO (OR AS A this certificate has been signed by the attending physician and con with the State Dept. of Health and Mental Hygiene prior to burial, with the State Dept. of Health and Mental Hygiene prior to burial, rked, or Item 23 shows any Injury, or other traumatic ex CERTIFICATION Sequentially list conditions, if any, leading to immediate . Enter UNDERLYING CAUSE (Disease or injury that initiated eventa Injury, or other resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24a. WAS AN AUTOPSY 1 YES 2 NO 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 | YES 2 | 1 Dinpetient 2 ER/Outpetient 3 DOA 5 Residence 8 - Other (Specify) 4 Nursing Ho 27. MANNER OF BEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED marked, Netural
Accident В 1 YES 2 NO After death Investigation TO THE FUNERAL DIRECTOR: After be filed within 72 hours after deat IMPORTANT: If Item 28 is m 3 Sulcide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) COMPLETED 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of exami 394 SIGNATURE AND TITLE OF CERTIFIER TO THE P BE 2 AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF 0 32 REGISTRAD'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

IF UNDER 1 YEAR

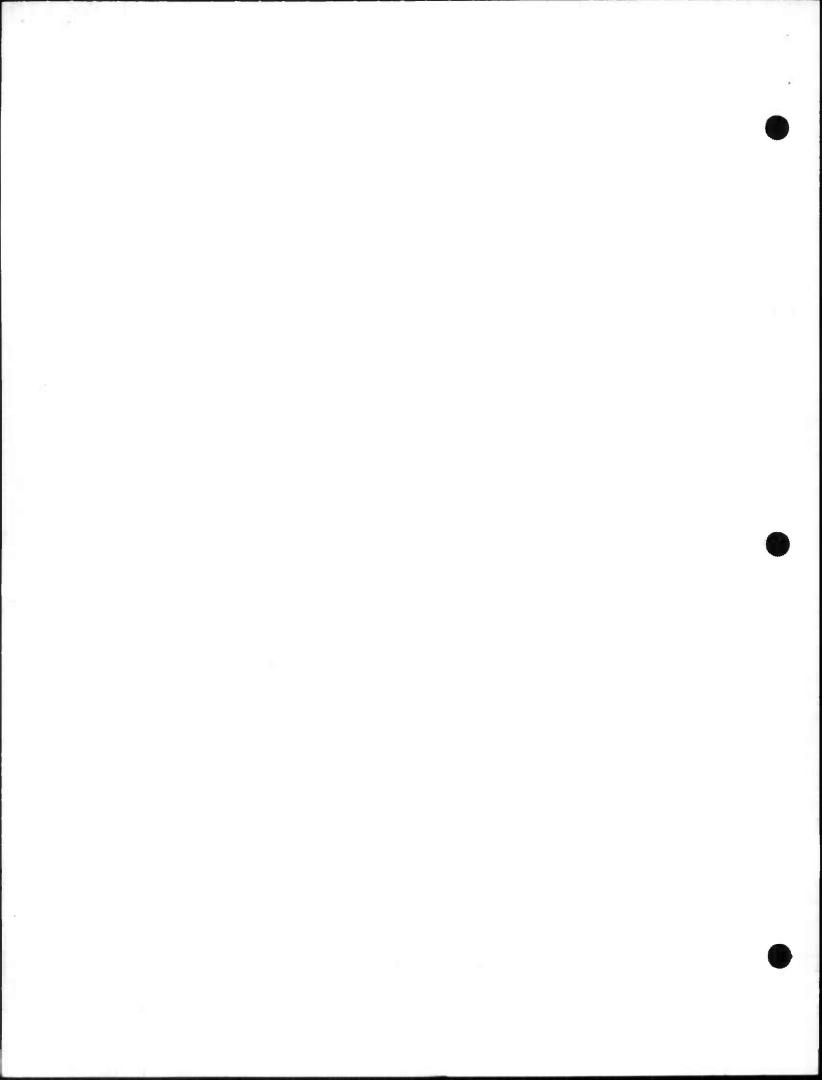
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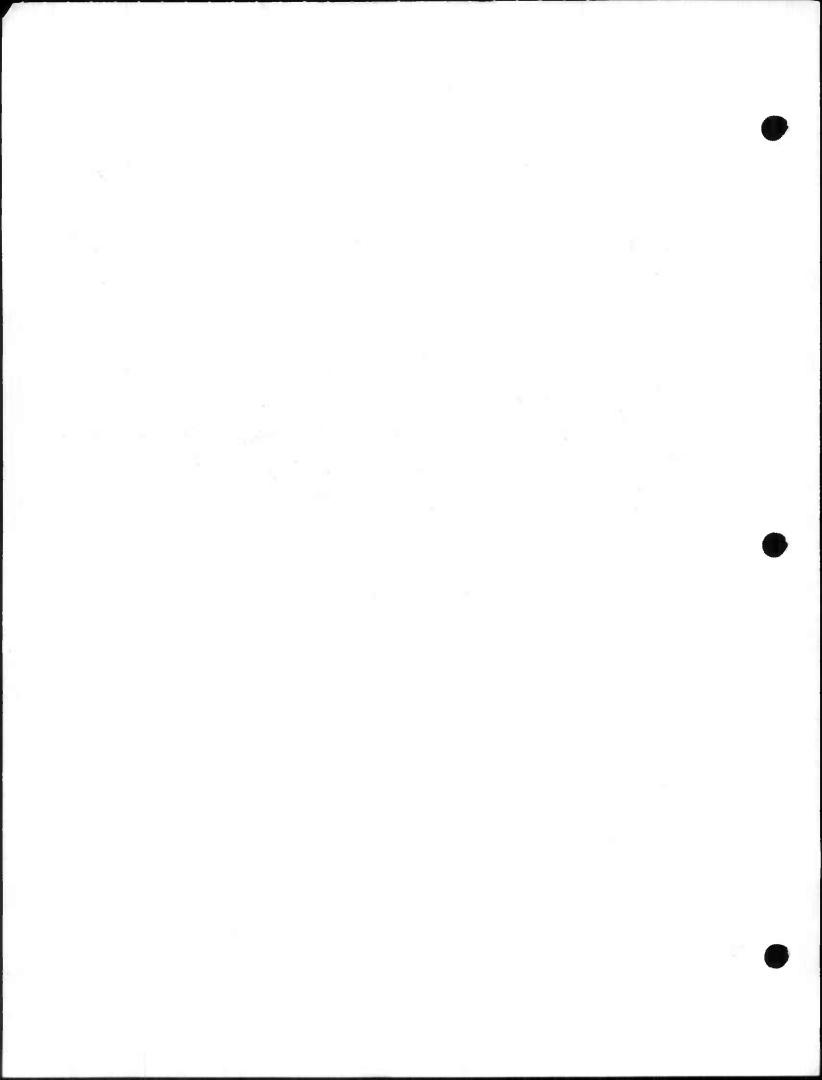
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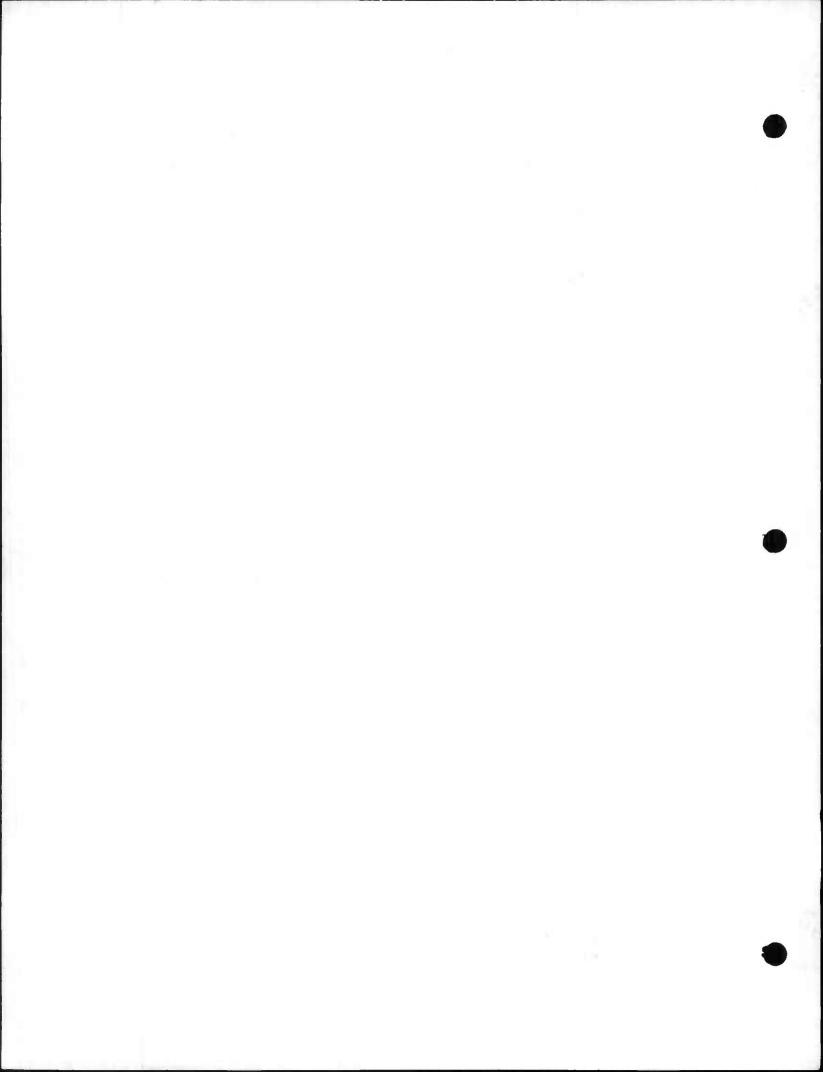
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		ACCOUNT NAME OF A MARK OF	
	1	1. DECEDENT'S NAME (First, Middle, Last)  2. DATE OF DEATH MONTH DAY 155 N	) м
		4. SOCIAL SECURITY NUMBER  6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH B. BIRTHPLACE (State or Follow)	gn
should	l d	10/15/69 //12.	
3 sh	H.	Sina Hospital Battimore, MD Buttimore	
1. 2,	CTOR	RESIDENCE OF DECEDENT	
Pages	DIRE	10a. STATE 10b. COUNTY 10c. CITY TOWN OR LOCATION 10d, INSIDE CITY LIMITS?	
permit.		1 TYES 2 NO  100-STREET AND NUMBER  101. ZIP CODE  109. CITIZEN OF WHAT COUNTRY?	)
TST.	FUNERAL	2944 Cliston Ave 21216 U.S.A	
020 physician. burlal-transit	FU	11. MARITAL STATUS  12. WAS OECEDENT EVER IN U.S. ARMED 12. WAS OECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No- 14. RACE — American Indian, 15. Was Decendent of Nispanic Origin? (Specify Yes or No- 16. If yes, specify Cuban, Mexican, Puarto Rican, etc.)  14. RACE — American Indian, 15. Black, Whita, atc.	
g a	ВУ	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATE! 1 YES 2 NO Specify: Specify:	
or attend	ETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working	
N 2 6	PLE	Elementary/Secondary (0-12) College (1-4 or 5+)  Truck Vin Ve V  Delivery	
The hospit detached	COMPL	17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname)	_
6 6 6	BE C	Gary Itolley Sheila Harcum	
ay be retained page 5 should be notified	10	She; a Caldwell 2944 Cl. From Alk Ballo Made 21216	
e 6 m rector,		20s. METNOD OF DISPOSITION  1 S Burlel 2 Cremation 3 Removal from State  20b. PLACE AND DATE OF DISPOSITION (Name of comety), cremating or other place)  20b. PLACE AND DATE OF DISPOSITION (Name of comety), cremating or other place)  20b. PLACE AND DATE OF DISPOSITION (Name of comety), cremating or other place)  20b. PLACE AND DATE OF DISPOSITION (Name of comety), cremating or other place)	
SAL r death ne fune al.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF EACHLY  Douglass Frank of Service	
4 × E 3		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line.	
- do -	-	IMMEDIATE CAUSE (Finel	
ted within 24 completely fill ial, cremation: event, the		disease or condition resulting in death)  a. DUE TO (OR AS A CONSEQUENCE OF)	
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	5	if any, leading to immediate	
e beat o	5	CAUSE (Disease or Injury  CLUSSE (Disease or Injury  DUE TO (OR AS A CONSEQUENCE OF):	
n certific inding p Hygiene	ERTIFICATION	resulting in death) LAST	
deati deati atte emtal	0	PART II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDS	
T = 5 = -	EDICAL	PERFORMED? AMAILABLE PRIOR TO COMP ETOM OF TAIL	
Sign Sign		OF DEATH?	
he law requires been so bept. of h	Z Z	1   YE\$ 2   NO	
AN: The law ifficate has is State Dept	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:	
SICIAN: The certificate h the State [d, or item	14Si	1 YES 2 NO 1 Inpettent 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Rasidence 8 Other (Specify)	
그 도 등 후 후	ву РНУ	1 Metural 5 Pending (Month, Day, Year) INJURY WORK? 2 Accident Investigation M 1 YES 2 NO	
L OR ATTENDING P. DIRECTOR: After the hours after death view 28 is mark		3 Suicide 8 Could not be determined 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28s. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
TO THE HOSPITAL OR A TO THE FUNERAL DIREC be filed within 72 hours IMPORTANT: If Item	COMPLETE	29a. CERTIFIER (Check only one)  1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.  2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as state	ıd.
HE HOW	ш	296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)	
6 6 3 MI	10 B	Dann hedbetter in pas 9722 > 4/6/93	
		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  Down Liberter, MD Sina Appoint of By the save	
		Dawn CONDITTE, MD Sinm Hospital Of Buttimere 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	/
V		ADD 08 1993 July Builson Randelle	
		THE THE PERSON NAMED IN COLUMN TO SERVICE AND ADDRESS OF THE PERSON NAMED ADDRESS OF THE PERSON NAMED IN COLUMN TO SERVICE AND ADDRESS OF	-



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

2.21215-0020 bital or attending physician. Id for use as the burial-transit permit. Pages 1, 2, 3 should	PLETED BY FUNERAL DIRECTOR	1. DECEDENT'S NAME (First, Middle, Last)  4. SOCIAL SECURITY NUMBER  5. SEX  6. AGE (In yrs. lest birthday)  98. FACILITY NAME (If not institution, pive street and number)  109. STATE  1	
IMORE, MARYLAND  Page 6 may be retained by the hospital if director, page 5 should be detached to ner must be notified at once.	TO BE COMPL	17. FATHER'S NAME (First, Middle, Last)  18. MOTHER'S NAME (First, Middle, Meiden Surname)  190. INFORMANT'S NAME (Type/Pylly)  190. MAILING ADDRESS (Street and Number or Fural Route Number, City or Town, State, Zip Code)  212. 3  200. METHOD OF DISPOSITION  100. PLACE AND ATECOPY DEPOSITION (Name of Donation 3   Removal from State)  210. PLACE AND ATECOPY DEPOSITION (Name of Donation 5   DATE DONATION - City or Town, State)  211. SIGNATURE OF FUNERAL SERVICE LICENSEE  122. NAME AND ADDRESS OF FACILITY	
O. BOX 68760,  BALT  certificate be executed within 24 nours after death.  ling physician and completely filled in by the funeral open to burial cremation, or removal.  other traumatic event, the medical exami	CERTIFICATION	23. PART I. Enter the diseases, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease)  Cause (Final disease)  ASUSTILE  DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death)  LAST DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):	
AL MECORDS, P. he law requires that the death of has been signed by the attence of bept. of Health and Mental H 123 shows any injury, or	MEDICAL	MEDICAL	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH (Check oth car).
TENDING PHYSICIAN: The TOR: After this certificate after death with the State 28 is marked, or Item	TED BY PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL  EXAMINER?  1 VES 2 NO  1 Inpetient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence \$ Other (Specify)  27. MANNER OF DEATH  1 Neturel 5 Pending Investigation 3 Suicide 6 Could not be determined  28. PLACE OF DEATH (Check only one)  27. MANNER OF DEATH  1 Neturel 5 Pending Investigation 3 Suicide 6 Could not be determined  28. PLACE OF INJURY  28b. TIME OF 28c. INJURY AT WORK? 1 YES 2 NO  28d. DESCRIBE HOW INJURY OCCURED  28d. DESCRIBE HOW INJURY OCCURED  28d. DESCRIBE HOW INJURY OCCURED  28d. PLACE OF INJURY AT WORK? 1 YES 2 NO  28d. PLACE OF INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED  28d. DESCRIBE HOW I	
TO THE PERMAL OR AT THE PRINCE OF AT THE PERMAN TO THE PERMAN TO THE PERMAN TO THE PERMAN THE PERMA	TO BE COMPLETE	29s. CERTIFIER (Check only one)  1. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.  2 MEDICAL EXAMINER: On the basis of szamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated.  2 DELICENSE NUMBER  29c. LICENSE NUMBER  29d. DATE SIGNED (Month, Day, Year)  4 4 4 5 3  30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
5.		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)  WALTER M SACUR MS SEPARAS LANGE ST. 225. GREENEST. RALDIMENTEN  31. DATE FILED (Abonto, Day, Year)  APR 08 1993 July Davidson Findelle  21201	



		1. DECEDENT'S NAME (First, Middle, Last) BABY	(DeVONTE'	L A M	ÀR H OWARD	OWARD	)	2. DATI	e of Death	. 19		5. TIME OF DEATH
P		4. SOCIAL SECURITY NUMBER NONE	5. SEX 6. A	GE (In yrs. les		IF UNDER 1 YEAR		7. DATE (Mon 3 -	1 2 - 1 9	I a		LACE (State or Foreign
2, 3 should	70R	9a. FACILITY NAME (If not institution, give to THE JOHNS :		PITAL			N OR LOCATION OF E	DEATH		9c. COUNTY	OF DEA	
020 physician. burial-transit permit. Pages 1,	DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNT	Y			TOWN OR LO						Od. INSIDE CITY LIMITS? YES 2 NO
n. ansit permi	FUNERAL	100. STREET AND NUMBER 6243 ROBIN H	ILL ROAD				101. ZIP CODE 21207			10g. CITIZEN	OF WH	AT COUNTRY?
5-0020 inding physicia as the burial-tr	BY FUN	11, MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 Y IF YES, GIVE WAR OF	ES 2 N	MED IO	13. WAS D	ECENDENT OF HISPA specify Cuban, Mexic ES 2 X NO Spec	ANIC ORIGI an, Puerto ily:	N? (Specify Yea Rican, etc.)	or No 14.	RACE - Black, V Specify:	- American Indian, White, atc.
2121 al or atte	OMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	(Gi	CEDENT'S U ive kind of wo Do NOT use	SUAL OCCUPA ork done during retired.)	ITION most of working	16/	b. KIND OF BUS	INESS/INDUS	TRY	
MARYLAND retained by the hospit 5 should be detached	E III	17. FATHER'S NAME (First, Middle, Last) DERON HOWARD					18. MOTHER'S N	AME (First,	PRIV	ETTE		
	TO BI	190. INFORMANT'S NAME (Type/Print)  MICHELLE HOWAR	D				N HILL		BAL	T0. №	ID	21207
ALTIMORE, death. Page 6 may be funeral director, page	ts e	20a. METHOD OF DISPOSITION  1) Burlal 2 Cremation 3 Ram  4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LIN	oval from State	206. PLACE A	MD DATE OF		PARK		93 RANDA			i, Stata
- 0 =	examiner	- Glynis	S. Leo	H		4300	AND ADDRESS OF F. H FUNER ) WABASH	AVE	E. BAL	TO.,	MD	21215
760, ed within 24 hours ompletely filled in the	numatic event, the medical	23. PART I: Enter the diseases, or shock, or hart feliure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	List only one cause of	Pun S A CONSECTIVE LIST	DUENCE OF		gence 8			atory arreat	,	Approximate interval Betwee Onset and Det 3 who
P.O. I sath certific attending ph tal Hygiene	ry, or other traumatic	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR A	S A CONSEQ	UENCE OF):							
ECORE  Tuires that the signed by Health and	MEDICAL	PART II. Other significent condition	s contributing to deat	h but not re	esulting in	the underly	ing cause given in	Part i.	24e. WAS AN A PERFORM	MED?	AV CC Of	FERE AUTOPSY FINDING WILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?  YES 2 NO
- S S	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO	HOSPITAL:	Putpatient 3		OTHER:	PLACE OF DEATH (Co					
OF PHYSIC this cer	marked, or BY PHY:	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJUR (Month, Day, Yee	TY	28b. TIME INJUI	OF 28c. I	NJURY AT WORK?  YES 2 NO		SCRIBE HOW IN	JURY OCCUR	ED	
ISIC TTEND TTEND TOR: 4	Z8 IS	3 Suicide 8 Could not be determined	28s. PLACE OF INJU- building, stc. (S	JRY — At hor Specify)	ne, farm, str	eal, factory, of	fica	28f. LOC City	ATION (Street ar or Town, State)	nd Number or I	Rural Rout	te Number,
B B R	COMPLE		CIAN: To the best of my kn R: On the besis of examins								luse(s) sr	nd manner as stated.
E E E	A P	296. SIGNATURE AND TITLE OF CERTIFIER					29c. LICENSE NU	MBER		29d. DATE SI	GNEO (M	fonth, Day, Year)
1	2	30. NAME AND AGORESS OF PERSON WH	s Hopkins	5 Ho	Spike	Prine)						
o 'V		APR 40.8 199	32 June Deur	QNATURE A	ndell	lu	200					

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

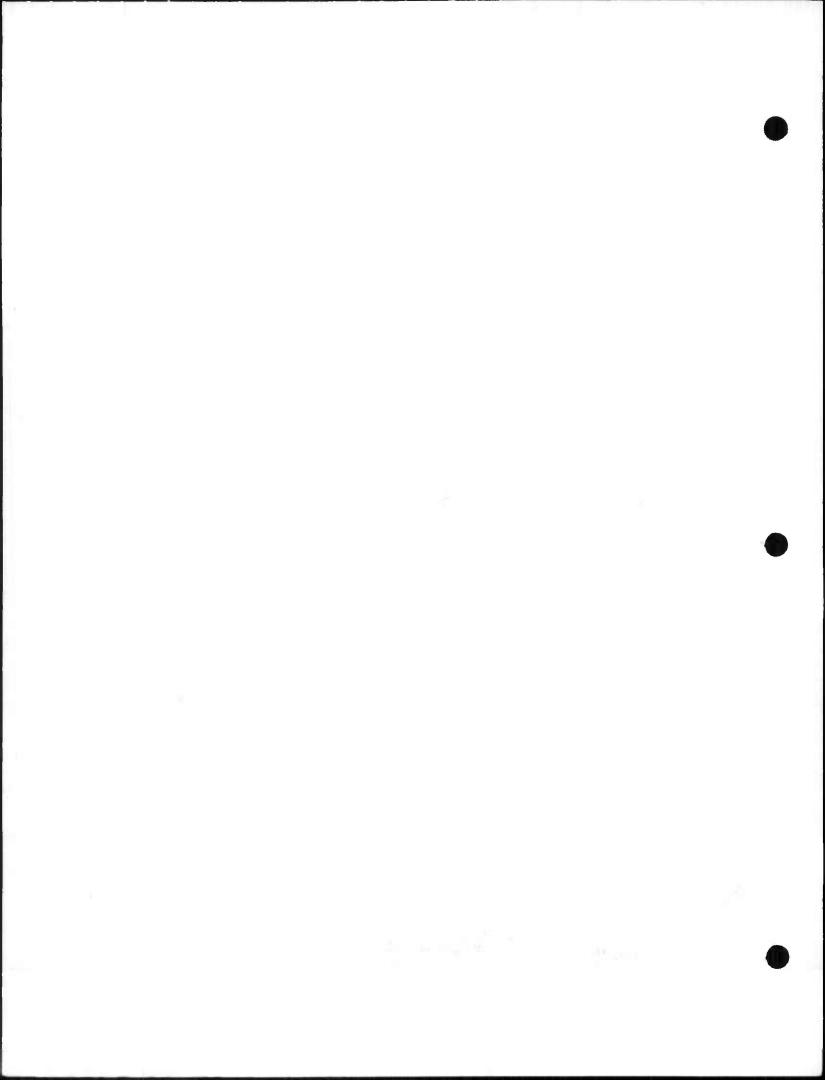
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Approximate Interval Between Onset and Death 3 who

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

6:38 Pm

REG. NO.



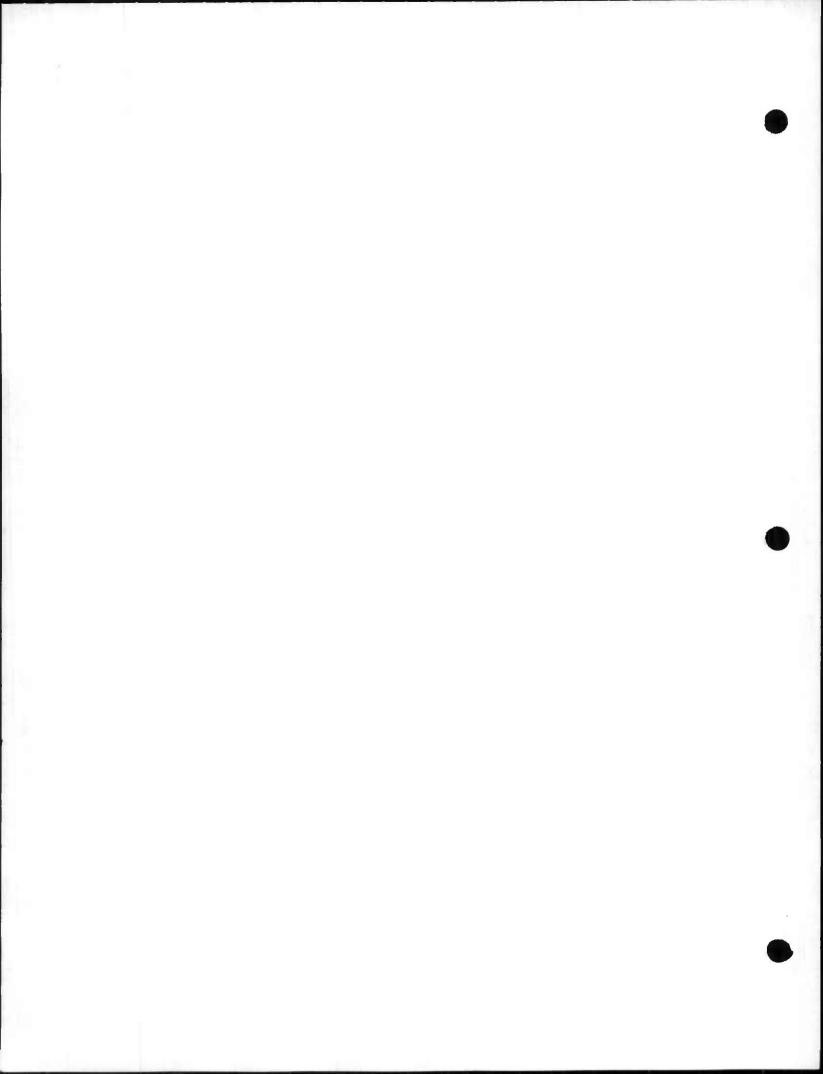
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL, OR ATTENDING PHYSICIAN. The law implies that the death certificate be secoled within 24 Novis after death. Page 6 may be minimed by the hospital or attending physician.

TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and competinfy filled in by the funeral director, page 5 should be detached for use as the burst-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the Suns Dept. of Health and Mental Hygiens prior to burist, cremation, or removel.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTMI CERTIFICA				GIENE G. NO.		J J U L		
		new FRANCES	GERTRUDE	JONES	1	2. DATE OF DEATH 3-28- WONTH DAT 28-			7 10 s		
	4. SOCIAL SECURITY NUMBER 213 09 3789  Bis. FACILITY NAME (# not institution, give	1□ 12 28 7 84	YRS. WONT	HE DAYS HO	NUMB MINL	/Month, Day. 7-16-	1908	Mar	yland		
TOR	Pikesville Nurs			Pikesvi]	ocation of DEAT Lle	н	1,155,000,000	timo:	re co		
DIRECTOR	Maryland Maryland	na na	Balti	m on Location jmore					TOIL INSIDE CITY LIMITE? 1 YES 2 NO		
FUNERAL	3409 Greenway	1		10f. ZIF	21218			USA	HAT COUNTRY?		
ВУ	1 XX Never Married 2 Married 3 Widowed 4 Divorced	13. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	If yes, specify	ENT OF HISPANIC Cutien, Mexicen, I NO Specify	ORIGIN? (Spe Puerto Rican, i	city Yes or No	14. RACE Black Specif	ACE — American Indian, act, White, etc.		
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad) Elementary/Secondary (0-12)	College (1-4 or 5+)	Give And of work of the Do NOT use recen	one during most of ed.)	working		of muswess/mo	*****	pany		
OM	ST. FATHER'S NAME (First, Middle, Last)			19.	MOTHER'S NAME	EFFort, Michille, J	Maidan Signamu)	-			
	John Washington	Jones			eneva Si		ornoven seedeman.				
BE C	19a. INFORMANT'S NAME (Type/Print)		195. MAJLING ADDR				or Town, State, Zip	Code)			
5	Js Jacqueline H	orner					re, MD 2				
	20e. METHOD OF DISPOSITION 1 □ Burtal 2.□ Gramation 3 □ Ran 4	novel from State 205.F	LACE AND DATE OF DIS	POSITION (Name o			Rise. LOCATION —	-			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bonald Wade, Dir 4/7/93 655W.Baltimore St,Balto,MD 21201										
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)										
- 1		DUE TO (OR AS A CONSEQUENCE OF):									
ATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING										
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):									
MEDICAL C	PART II. Other significant condition	ns contributing to death but	not resulting in the	underlying ca	use given in Pa	NT I. 34n WAS AN AUTOPSY PERFORMED?			24b. WERE AUTOPSY FINDINGS AWAILABLE PROR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	Law		OF DEATH (Chick	only one)		1_			
YSI	1 TES 2 ONO	1. [] Impatient 2 [] ER/Output		REFE: Nursing Home 5	☐ Residence & □	Other (Speci	n/)				
ВУ РН	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28s. DATE OF INJURY (Month, Day, Year)	28h. TIME OF INJURY	29c, INJURY WORKY 1  YES		M. DESCRIBE	HOW BUURY OCC	UNED			
	3 Suitcide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — building, etc. (Specify	At hame, farm, street,	factory, office	36	Gity or Them	ON (Street and Number of Rural Route Number, River, State)				
COMPLETED	CONCE HITE TO MEDICAL EXAMINE	CIAN: To the best of my knowled ER: On the basis of examination a	ige, death occurred at the	ne time, date and ny opinion, death	place, and due to occured at the time	the cause(x) as e, date and plu	nd manner as state ace, and due to the	nd. r cause(x)	and manner as stated.		
BE	296. SIGNATURE AND TITLE OF CERTIFIE	A Poble	-d	10 7	OCENSE NUMBE	77	29d. DATE	SHOWED !	Morrin Proj. Warr)		
2	30. WANTE AND ADDRESS OF PERSON WY	O SOMPLETED CAUSE OF DEAT	H (STEM 27) (Type, Print)	PAS	100	Ver,	ild	2/	200		
	" APR -8 1993	COL REGISTRATIO SIGNAT	die			1					



		1 - FOR STATE REGISTRAR	STATE OF MAI	RYLANI	) / DEPAR	TMENT	OF H	EALTH /	AND MI	ENTAL HYGIEN REG. NO.		<i>J</i> U	09903
		1. DECEDENT'S NAME (First, Middle, Last)							1	P. DATE OF DEATH DATE	ıv	YEAR 3.	TIME OF DEATH
		Patricia 4. SOCIAL SECURITY NUMBER	a Ehrma Kr							93	1:48 am		
P		213-66-8095	1 □ M 2 \ F	36	. lest birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER 2 HOURS	MIN. A	ug. 25,	.956	Mary	ce (State or Foreign
2, 3 should	OR	Se. FACILITY NAME (If not institution, give street and number)  9b. CITY, TOWN OR LOCATION OF DEATH  Baltimore  9c. COUNTY OF DEATH  ———											
pril .	띮	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN O	RIOCAT	ION				100	A MINIOS CUTY
permit. Pages	L DIRECTOR	Maryland -				Bal	timo	re				1X	1. INSIDE CITY LIMITS? XYES 2 \(\sum \) NO
	FUNERAL	2821 Erdman Ave.					101.	ZIP CODE	010		17	EN OF WHAT	
020 physician. burtal-transit	NS.	11. MARITAL STATUS	12. WAS DECEDENT EV	/ER IN U.S.	ARMED	13.1	MAS DEC		.213	ORIGIN? (Specify Yas		S. A.	American Indian,
21215-0020 al or attending physician for use as the burial-trai	BY FI	1 Merried 2 Married 3 Divorced	FORCES? 1 []	YES 24	<b>∑</b> NO	1	yes, spe	clty_Cuban,	Mexican, Specify:	Puerto Rican, etc.)	Or NO.	Black, Wi Specify:	
215 attences	G	15. DECEDENT'S EDUC (Specify only highest grade		16a.	DECEDENT'S	USUAL OC	CUPATIO	ON and weedless		16b. KIND OF BUS	SINESS/INDU	JSTRY	
	COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)		life. Do NOT us	retired.)	uring mos	st or working					
AND the hosp detached	₩	NA 17. FATHER'S NAME (First, Middle, Last)	NA		Clerk					Bank			
MARYLAND 212- retained by the hospital or att 5 should be detached for use notified at once.		John E. Kratz								(First, Middle, Maiden re M. Joh			
	BE	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS	(Street a)			te Number, City or Town		Code)	
M/ e reta e 5 st	2	Eleanore Kratz (M	Mother)							ltimore,			
RE, MAR may be retained or, page 5 should set be notified		20a, METHOD OF DISPOSITION 1 💢 Burlal 2 🗆 Cremation 3 🗀 Ramo	and from State		CE AND DATE	OF DISPOS						ity or Town,	State
O Se 6		4 Donation 5 Other (Specify)		LC	crematory or of	e Par	k Ce	emete	rv	4/9 Woo	dlawn	, Mary	yland
ALTIMOR death. Page 6 ma e funeral director, p. 	}	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE			22. I SC	AME AN	D ADDRESS	of FACIL	al Home			
		MILLE								ne, Balti	more,	Md.2	1213
in 24 hours by filled in thation, or re-		immediate cause (Fine)	List only one cause on each line.								Approximate interval Between Onset and Death		
certificate be nding physician Hygiene prior t or other trau	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Dissass or injury that initiated events resulting in death) LAST			HO OU ISEQUENCE OF		pe	lvic	tui	Moy			
RECOR requires that been signed by of Health an shows any	MEDICAL	PART II. Other significant conditions PEIVIC HUMOY					derlying	ceuse glv	ven in Pa	rt I. 24s. WAS AN PERFOR	MED?	CON OF	RE AUTOPSY FINDINGS R. ABLE PRIOR TO MPLETION DF CAUSE DEATH?  YES 2 70
VITAL F AN: The law tificate has be e State Dept. or Item 23 s	PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL					26. PL	ACE OF DEA	TH (Check	only one)			
VITA	YSK	EXAMINER?  1 YES 2 NO	HOSPITAL: 1 Inpetient 2 ER	/Outpatient	3 DOA	OTHER		5 🗆 Resi	dence 6	Other (Specify)			
	H	27. MANNER OF DEATH  1 Netural 5 Pending	28a. DATE OF INJU		28b. TIM	E OF URY	28c. INJU	JRY AT N	14 2	d. DESCRIBE HOW IF	NJURY OCCU	PRED	
ON OF DING PHYS After this of death with	B	1 Netural 5 Pending 2 Accident Investigation	NIA		NA	M	_	ES 2	NO	NIA			
28 L	ETED	3 Suicide 6 Could not be determined	28a. PLACE OF IN. building, etc.	JURY — At (Specify)	N/A	treet, facto	ry, offica		21	Sf. LOCATION (Street a City or Town, State)	and Number o	r Rural Route	Number,
= = = = = =	COMPLI	298. CERTIFIER (Check only one) 2 MEDICAL EXAMINER											f menner se stated.
TO THE HOSPITA TO THE FUNERA Be filed within 72 IMPORTANT: II	TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER	Buch	J, ,	UD			29c. LICEN					nth, Day, Year)
		30. NAME AND ADDRESS OF PERSON WHO BOWLEY	COMPLETED CAUSE O	E. Ur	TEM 27) (Type	Prine)	KW	ay	Bal	timore	2, Hi	09	1218
		APR 08 1993	o 32. REGISTRAR'S	SIGNATUR Pond	E								

5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hos,	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached		IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	ı
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	after	by th	THOVA	cai	İ
	SINC	.S	I re	peu	ı
	24 IN	filled	00,0	he n	
	hin	tely	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.	f,	
	wit	тре	Cre	wen	
	cute	00 p	urial	lic	l
	900	n an	to D	ma	l
	e pe	sicial	rior	trau	
	ficat	phy	ne p	her	l
	Cent	ding	tygie	6	I
	eath	atten	rtal P	у, о	l
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	J AND	s be	ept.	3 8	ĺ
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	FOR 1 - STATE REGISTRAR	STATE OF I	MARYLAND C	/ DEPAI	RTMEN	T OF H	HEALTH DEA	AND M		IYGIEN			
- 8	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF			13	TIME OF DEATH
	Ross (Ted)	Ko	ontz						April		1993	YEAR	:05 P
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. le	ast birthday)	JE UMDI	ER 1 YEAR	IF UNDER	_	7. DATE OF				ACE (State or Foreign
- 9	194-03-9493	1 ☑ M 2 ☐ F	87	YRS.	MONTHS	-	HOURS	MAIN	(Month, De	ly, Ybar)		Country)	
	9a. FACILITY NAME (If not institution, give st	4.5	07						une 2	U, 1			rd, Pa.
<b>α</b>					96. CIT			ON OF DEA	TH		9c. COUN	TY OF DEAT	Н
0	5319 Selfridge Av	<i>7</i> e				B	alti	more				-	
DIRECTOR	10e. STATE 10b. COUNTY	,		10c CI1	WWOT Y	OR LOCA	TION	_				1 40	d. INSIDE CITY
E I	Maryland -					more							LIMITS?
7	10e. STREET AND NUMBER					-			-				YES 2 NO
FUNERAL						10	f. ZIP COD	_			10g. CITIZ	EN OF WHA	T COUNTRY?
뿐	5319 Selfridge Av							1205_					U.S.A.
5	11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. A	BMED NO	13	If yes, so	ENDENT (	OF HISPANIC	C ORIGIN? (S	pecify Yes	or No-	14. RACE — Black. W	American Indian, Thita, etc.
BY	3 Widowed 4 Divorced	IF YES, GIVE V	WAR OR DATES			1 TYES	2 NO	Specify:	Puerto Rica			Specify:	White
	15. DECEDENT'S EDUC	NATION!	Tract of								1		Valle
=	(Specify only highest grade	completed)	16a. D	ECEDENT'S Give kind of le. Do NOT u	work done	OCCUPATION DO	ON ost of worki	ng	16b. KIR	ID OF BU	SINESS/INDU	JSTRY	
7	Elamentary/Secondary (0-12)	College (1-4 or 5	+)							~1			
COMPLETED	NA NA	NA	Mec	hani	Cal	WOLK	_				ical (	compa	ny
8	17. FATHER'S NAME (First, Middle, Last)								E (First, Midd		Sumame)		
BE	Charles W. Koontz	3							Beckl	-4			
2	19a. INFORMANT'S NAME (Type/Print)  19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
	Helen H. Koontz (Wife) 5319 Selfridge Ave., Baltimore, Md. 21205												
	20a. METHOD OF DISPOSITION 1   Burlal 2   Cremation 3   Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Completely, cremeter, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremeters, cr												
	St. Paul's Celletery 4// BedTord, Pennsylvani												
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	-		22	. NAME A	ND ADDRE	SS OF FACI	UTY TT				
	1/1/1//								ral H				
	23. PART I. Enter the diseases or c	omplications the	t caused the d	eeth Do	3	331 .	Bren	ns La	ne, B	altı	more,	Md.	
	anock, or haart failure. List only one cause on each line.												Approximata Interval Betwee
													Onset and Deal
- 1	resulting in death)												
1	DUE TO TOM AS A CONSEQUENCE OR):												
N	Sequentially list conditions.	DUE TO (OR AS A CONSEQUENCE OF):								_			
ERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	DUE TO	(OR AS A CONSE	ONENCE O	Fit								
3	CAUSE (Disease or Injury												
Ë	that initiated events resulting in death) LAST	006 10	(OR AS A CONSE	QUENCE O	F):								l
CER		1											
	PART II. Other algnificant conditions	a contributing to	death but not	rasulting	In the u	ndarlyin	g cause (	given in P	art I. 24	. WAS AN	AUTOPSY	24b. WE	RE AUTOPSY FINDINGS
MEDICAL										PERFOR			AILABLE PRIOR TO IMPLETION OF CAUSE
입									-   10	YES 2	□ NO	OF	DEATH?
									-			1 [	YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL					00 84	105.05.0				<del></del>		
[ [	EXAMINER?	HOSPITAL:			OTHE		AGE OF D	EATH (Chec	k only one)				
¥	1 YES 2 NO	1 Inpatient 2		_	_				Other (Sp				
	1 Natural 5 Pending	(Month, D		28b. TIM	IURY		RK?		28d. DEŞCRII	BE HOW I	NJURY OCCL	JRED	
B	2 Accident Investigation						YES 2	NO					
ED	3 Suicide 6 Could not be	28s. PLACE O building,	F INJURY — At he etc. (Specify)	ome, farm,	streel, fac	ctory, offic		1	28f. LOCATIO City or To	N (Street a wn, State)	ind Number o	r Rural Rout	Number,
교	29e. CERTIFIER (Check only 1 CERTIFYING PHYSIC	CIAN: To the best of	my knowledge, d	eath occurr	ed at the	time, date	and placa	, and dua to	the cause(s	) and mar	mer se state	d.	
COMPLET	0.000												d manner as stated.
Ö	NO. SIGNASTICE AND TET BASE PRIVATE IN												
m	XX	V.	1						z *		V	1/2	7 2
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED ONLY									1	101	

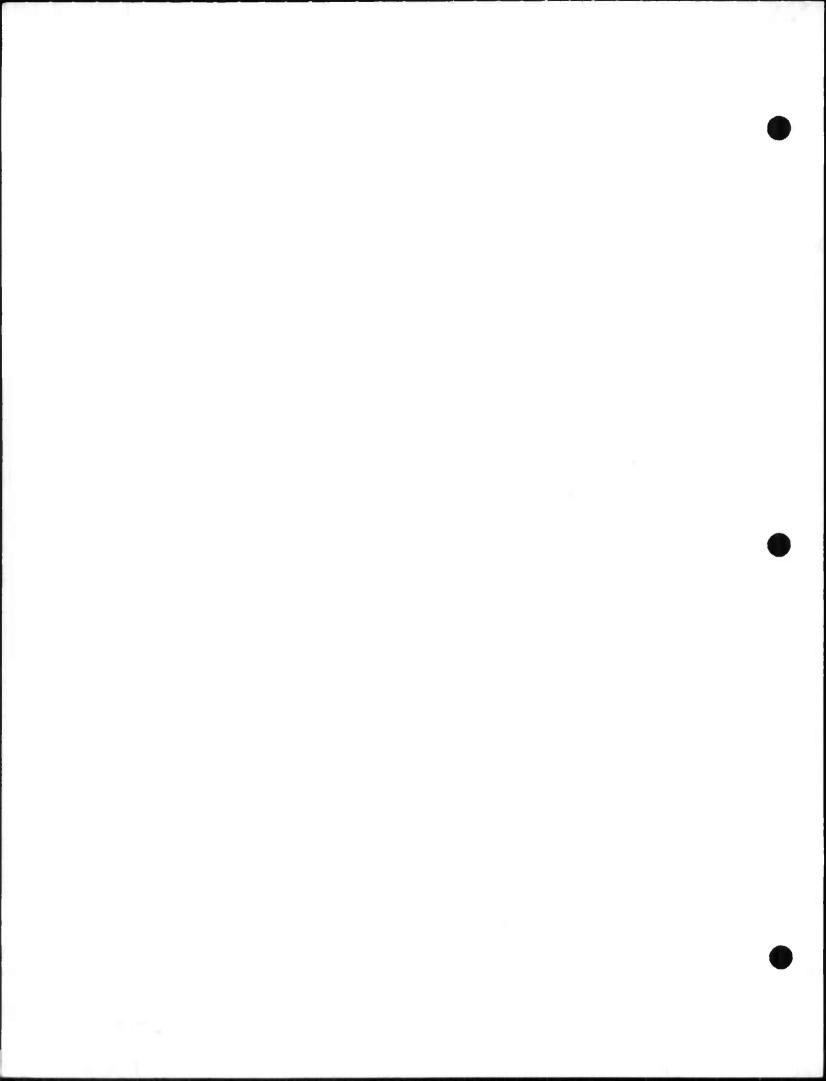
WHO COMPLETEO CAUSE OF OEATH (ITEM 27) (Type, Print)

Irwin Nudelman, Eastpoint Medical Center, 1012 Old North Pt Rd., Balto, Md.

122. REGISTRAR'S SIGNATURE

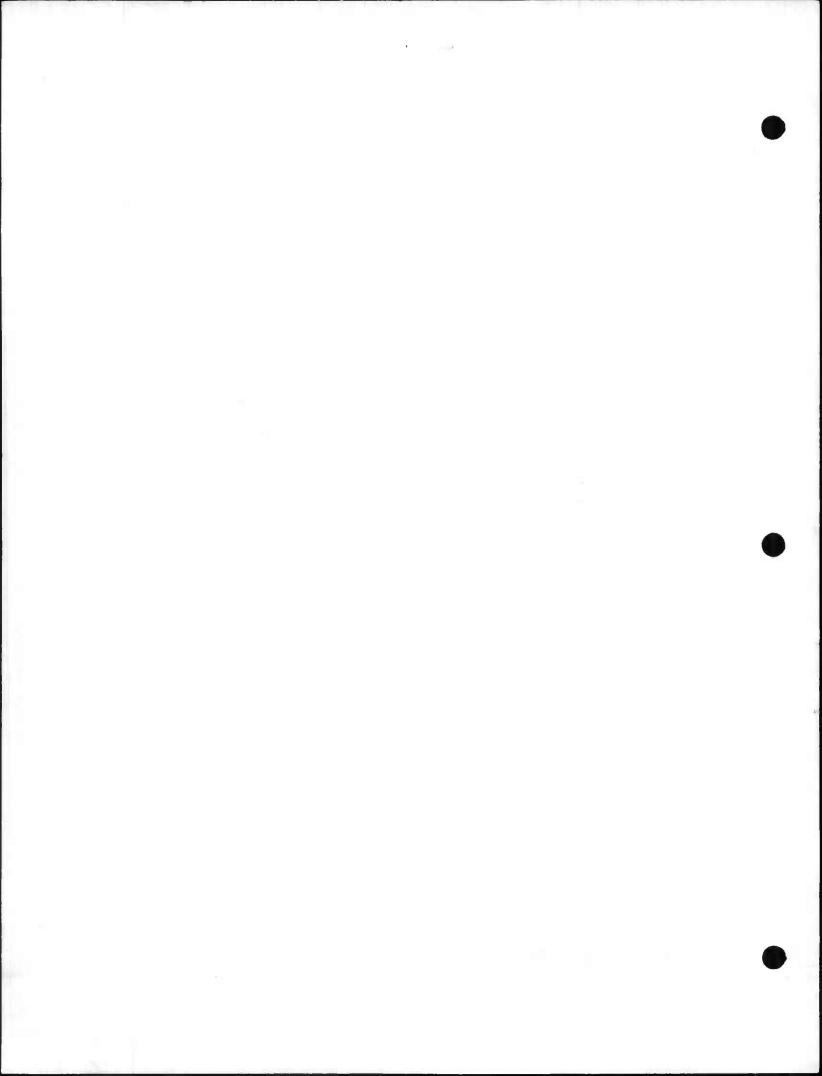
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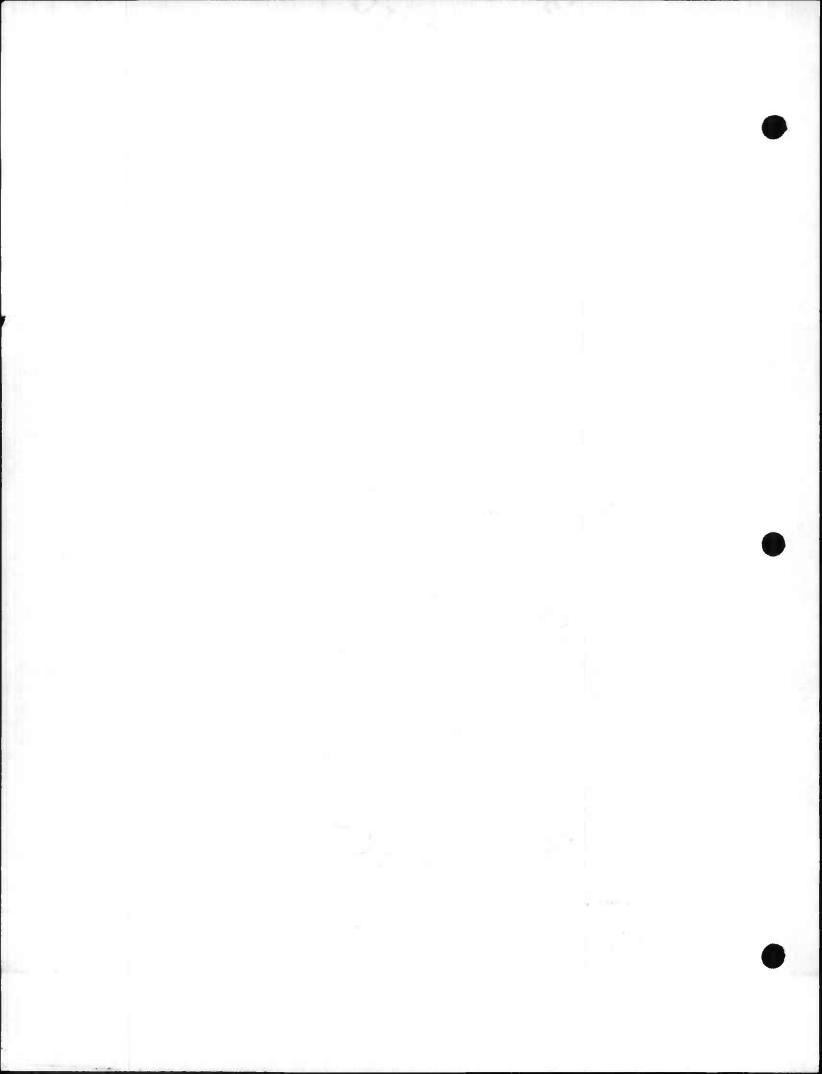
_		1 - FOR STATE REGISTRAR	ATE OF MARYLAND /		T OF HEALTH AND E OF DEATH	MENTAL HYGIENE REG. NO.	
	ć.	1. DECEDENT'S NAME (First, Middle, Lest)	M - E	<i>u</i> .		2. DATE OF DEATH MONTH DAY	YEAR 3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER 5. SE	Many F.  8. AGE (In yrs. les	King	Township of the second	4-5-1993	
plnous			M 2 ⊠ F 94	YRS. MONTHS	R 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)  1 1 - 4 - 1898	8. BIRTHPLACE (State or Foreign Country)
		9a. FACILITY NAME (If not institution, give street en	d number)	9b. CIT	Y, TOWN OR LOCATION OF D		DeLaware  c. COUNTY OF DEATH
2,3	6	Good Samaritan H	ospital		Baltimo	re	
Pages 1,	DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY		10c. CITY, TOWN	DR LOCATION		10d. INSIDE CITY
i <del>j</del> Se		Md		Ba.	ltimore		LIMITS?  †XEX 2 \( \text{NO} \)
sit permit.	FUNERAL	6126 Edlynne Rd			10f. ZIP CODE		0g. CITIZEN OF WHAT COUNTRY?
15-0020 ending physician. as the burial-transit	S	11. MARITAL STATUS 12. W	AS DECEDENT EVER IN U.S. AF			NIC ORIGIN? (Specify Yes or	
o physical principles	BY F		ORCES? 1 TYES 2XTX YES, GIVE WAR OR DATES	90	If yes, specify Cuben, Mexic  1 YES 2 NO Speci		Specify: White
215-0020 attending physic use as the burial		15, DECEDENT'S EDUCATION		CEDENT'S USUAL (	CCUPATION	16b. KIND OF BUSINE	
21 al or 10 for 1		(Specify only highest grade comple  Eigmentary/Secondary (0-12) Colle  O T. //	ife (1-4 or 5+)	. Do NOT use retired.;			
YLAND 2 by the hospital be detached to at once.	COMPL	17. FATHER'S NAME (First, Middle, Last)		memake		Hom	
	E C	William A. Goen	nen.Sn.			C. Gephan	
MARYLAND retained by the hospit 5 should be detached notified at once.	TO B	19a. INFORMANT'S NAME (Type/Print)	19	b. MAILING ADDRES	S (Street and Number or Rural	Route Number, City or Town, S	itate, Zip Code)
	-	Mrs. Ruth A. Gre					Md. 21239
BALTIMORE, er death. Page 6 may be the funeral director, page val.		20a. METHOD OF DISPOSITION  1/C Burlal 2 □ Cremation 3 □ Removal fro  4 □ Donation 5 □ Other (Specify)	om State 20b. PLACE	AND DATE OF DISPO	SITION (Name of	DATE 200 LOCAT	TON — City or Town, State
ALTIMOR death. Page 6 ma e funeral director, p al. examiner must		21. SIGNATURE OF FUNERAL SERVICE LICENSEE	Duzu	22	NAME AND ADDRESS OF E	KSII ITV	
BALT ter death. the funera oval.	9	Mostral	200	7.	artley Mi.	llen Funen	al Home to. MD.21234
n by remo		23. PART i. Enter the diseases, or complishock, or heart failure. List or	cations that caused the de	ath. Do not ente	the mode of dying, suc	ch as cardiac or respirate	ory arrest, Approximate interval Between
y filled i		IMMEDIATE CAUSE (Final disease or condition			1110	/	Onset and Death
- 60 6		resulting in death) a	DUE TO (OR AS A CONSE	OUENCE OF):	rolledouro	jezuno sh	7
	N	Sequentially list conditions, b.			folile		
OX 68 e be execute sician and c rior to buris traumatic	RTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONSE	QUENCE OF):			
Phy ne phy	JFIC	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CONSE	DUENCE OF):	re		
U + 5 5 5	CERT	resulting in death) LAST					
그 음을 들	AL C	PART II. Other significant conditions conf	tributing to death but not i	resulting In the u	nderlying cause given in		
T 4 6 5 -1	EDIC/	Afe				PERFORME	COMPLETION OF CAUSE
w requires that been signed pt. of Health a	2						1 TES 2 NO
AL le law has b Dept.	IAN:	25. WAS CASE REFERRED TO MEDICAL			26. PLACE OF DEATH (C)	meck only one)	
F VITA SICIAN: The certificate if the State , or item	PHYSICI		SPITAL:  npatient 2 - ER/Outpatient 3	DOA 4 Nu			
VISION OF VI ATTENDING PHYSICIAN: ECTOR: After this certificals after death with the St. 128 is marked, or the	F	27. MANNER OF DEATH  1 🔀 Netural 5 🗆 Pending	(Month, Day, Year)	28b. TIME OF INJURY	28c, INJURY AT WORK?	28d. DEŞCRIBE HOW INJU	RY OCCURED
ON O DING PHYS After this death with	B	2 Accident Investigation	860. PLACE OF INJURY — AI ha	me, Isrm, street, fac	1 YES 2 NO	28f LOCATION /Street and	Number or Rural Route Number,
DIVISIO OR ATTENDIN DIRECTOR: Att hours after des	回	4 Homicide determined	building, atc. (Specify)		,	City or Town, State)	THURSON OF PRINCES PROPERTY.
S S S S S S S S S S S S S S S S S S S	PE	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: 1	o the best of my knowledge, de	ath occurred at the	time, dete end place, and due	to the cause(s) and manner	ne stated.
TO THE HOSPITAL (TO THE FUNERAL (De fied within 72 h	COMPL	one) 2 MEDICAL EXAMINER: On t	he basis of examination end/or.	Investigation, in my	opinion, death occured at the	lime, dete and place, and de	ue to the cause(s) and menner as stated.
TO THE HOSPI TO THE FUNER TO Filed within	BE	29b. SIGNATURE AND TITLE OF CERTIFIER	M )		29c. LICENSE NU	MBER 29	Pd. DATE SIGNED (Month, Day, Year)
2 2 3 %	5	30. NAME AND ADDRESS OF PERSON WHO COM	PLETED CAUSE OF DEATH (ITE	M 27) (Type, Print)			P
		Khaldoun A. Del	siern 560	1 toch	Raver 1810	d Bal TI	mure, 1417, 21230
1	ĺ	31. DATE FILED (Month, Day, Year)	Laurdon-Randes	2.			
		APR 08 1993 94	Caratta Colonia No. 19-21	7.			



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OR	that
RECO	law requires that the death certificate be executed within 24 nou
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OF VI	HYSICIAN:
7	G.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	OR ATTENDING PHYSICIAN; The I
=	8
_	-
	HOSPITAL

1 - FOR STATE REGISTRAR CERTIFICATE OF DEATH 2. DATE OF DEATH DA -27 1. DECEDENT'S NAME (First, Middle, Lest) LANGTON TOTALTE 93R 3. TIME OF DEATH LANGWORTHY DEANE 1018 PM 3 A. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 5. SEX IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign MONTHS DAYS HOURS 1 🗌 M 2 🔲 F YRS. 044 22 8257 88 8-20-1904 Illinois use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 8200 Good Luck Road DIRECTOR MAGNOLIA GARDENS NUR HOME Prince George Co 10b. COUNTY 10a STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George co Bowie 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 12213 Wynmore Lane 20715 USA 24 hours after death. Page 6 may be retained by the hospital or attending physician, filled in by the funeral director, page 5 should be detached for use as the burial-tran 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY 1 WES 2 NO Specify: 3 Widowed 4 Divorced White no COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) E BE Elias Berg Waite Verne Howard notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Pural Route Number, City or Town, State, Zip Code) 2 12213 Wynmore Lane, Bowie, MD 20715 James Lunsden Pe 206. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must 4 Donation 5 Other (Specify) examiner 22. NAME AND ADDRESS OF FACILITY State Anatomy Board Ronald Wade, Dir 4/6/93 655 W. BaltimoreSt, Balto, MD 21201 nding physician and completely filled in by the Hygiene prior to burial, cremation, or removal. event, the medical 23 PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one ceuse on each line. interval Between MEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) PNEUMONIA, ASPIRADOND
DUE TO (OR AS A CONSEGUENCE OF): LISTER SENICE DEMENTIA YEARS traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease Dr injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events attending resulting in death) LAST 0 Mental F Injury, signed by the a Health and Men PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL any 1 YES 2 NO OF DEATH? shows a 1 TES 2 NO s certificate has been si th the State Dept. of Hi d, or item 23 show PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 TO NO 1 Inpetient 2 ER/Outpetient 3 DOA me 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED With Is marked, this 1 Netural 5 Pending 1 YES 2 NO BY death 2 Accident After 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined DIRECTOR: / COMPLETED 28 4 Homicide Item 29s. CERTIFIER

(Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. FUNERAL ( Ξ 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: It 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Vely M 022780 > 3/28/93 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 7500 Greenway (tr Nr. Creabelt Med 20770 Schissler 110 32 REGISTRAR'S SIGNATURE



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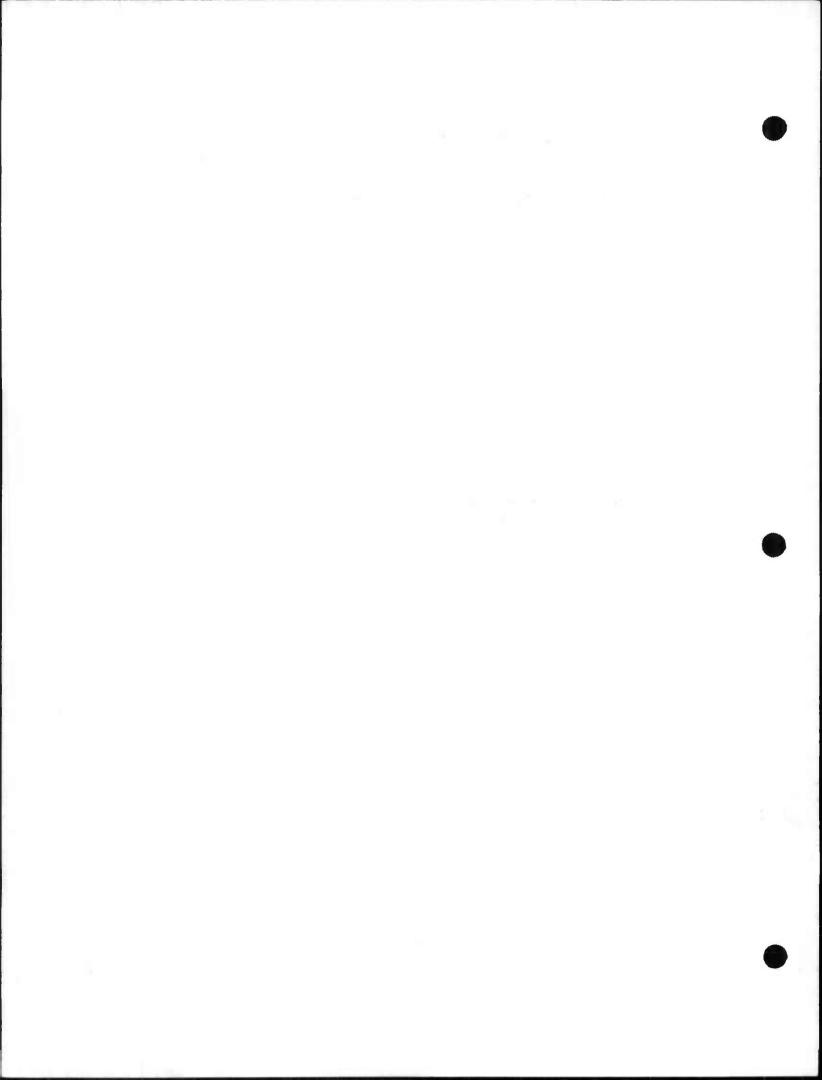
TO THE HOSPITAL OR ATTHENING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYL		MENT OF H		MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATN		3. TIME OF DEATH
	Joseph E.	Langstr					AY YE	9.40 P. M
		6. AGE (I		IF UNDER t YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 10-30-2		BIRTNPLACE (State or Foreign Country) ARYLAND
OR	9a. FACILITY NAME (If not institution, give street Union Memorial H				ore City		9c. COUNTY	OF DEATN
ן בַּ	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY		100 CITY	TOWN OR LOCAT	1011			
DIRECTOR		TIMORE	100. 011,	TOWN ON LOCAL	ION			10d. INSIDE CITY LIMITS?
FUNERAL	100. STREET AND NUMBER 2120 RIVERVIEW	ROAD			21221		USA	OF WHAT COUNTRY?
BY FUN	11. MARITAL STATUS  1\( \) Never Married 2 \( \) Married  3 \( \) Widowed 4 \( \) Divorced	2. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA NAVY WWII	2 NO	13. WAS DEC	ENDENT OF NISPA	NIC ORIGIN? (Specify Yean, Puerto Ricen, etc.) fy:	es or No— 14.	RACE — American Indian, Black, Whita, etc. Specify: H I T E
	15. DECEDENT'S EDUCAT (Specify only highest grade col	TION	18a. DECEDENT'S US	rk done during mos	N st of working	16b. KIND OF BL		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	MILL WR			ветн.	STEEL	
00	17. FATNER'S NAME (First, Middle, Last)					AME (First, Middle, Maider	Sumama)	
BE	OTTO LANGSTROM  19a. INFORMANT'S NAME (Type/Print)		111000000000		FRANCE			
5	MRS. ESTELLE LAN	NGSTROM				Poute Number, City or To.  D BALTO.		21221
	20g. METNOD OF DISPOSITION  1 D Burlat 2 Cremation 3 Remova  4 Donation 5 Other (Specify)	al from State 20b.	PLACE AND DATE OF	DISPOSITION (Nei	me of ETFRY	0ATE 200. LO	CATION — City	
	21. BIGNATURE OF FUNERAL SERVICE LIGHT		1:	KACZO	DADDRESS OF FA	FUNERAL	HOME	
	23. PART I. Enter the diseases, or eon	milicetions that caused	the deeth. Do no	t enter the mod	de of dying, aud	ST. BALT	U. MU. piratory arrest,	Approximate
	immediate cause (Fine) immediate cause (Fine) disease or condition	PULMO	ch line.					interval Between Onset and Death
	resulting in death)	DUE TO TOR AS A	CONSEQUENCE OF 1:					HOURS
N N	Sequentielly liet conditions, b	DEEP	CONSEQUENCE OF:	THA	OMBOJ	15		DAYS.
CATI	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury							
CERTIFICATION	CAUSE (Disease or injury that initiated events OUE TO (OR AS A CONSEQUENCE OF):							
AL CE	PART ii. Other aignificant conditions of	contributing to death bu	ut not resulting in	the underlying	cause given in	Part I. 24s. WAS AF	AUTOPSY	24b. WERE AUTOPSY FINDINGS
DICA	CORUNARY ARTI	ERY DISE	186,			PERFO	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDIC	CHROMAC OBSTR	PUCTIUE 7	PULMANA	AX DY	PENSE			1 TES 2 Q.NO
IAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			26. PL	ACE OF DEATH (Ch	eck only one)		
YSIC		IOSPITAL: Inpatient 2 - ER/Outpi		OTHER:	5 🗆 Rasidence	8 Other (Specify)		
	27. MANNER OF DEATN  1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME (	TY WO		28d. DESCRIBE NOW	INJURY OCCUR	ED
ED BY	2 Accident Investigation 3 Suicide e Could not be detarmined	28a. PLACE OF INJURY building, atc. (Speci	— At home, farm, stre			281. LOCATION (Street City or Town, State	and Number or R	tural Route Number,
LET	29a. CERTIFIER 1 CERTIFYING PNYSICIA	N: To the best of my knowle	adae death accurred	et the time date.	and oleran and star			
COMPLETED								use(a) and manner as stated.
TO BE	296. SIGNATURE INO TITLE OF CERTIFIER		VE RESI		29c. LICENSE NUI	MBER		MEO (Month, Day, Year) 4/02/93
F	30. NAME AND ADDRESS OF PERSON WHO CO TOSEPH PUTHUI	OMPLETED CAUSE OF DEA	TN (ITEM 27) (Type, PI	EMORI	1AL 1400)	P. E. UNIV	PKNY,	BALTIM ORE, MA
		da Javidaga-Ad						



DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a riours after death. Page 6 may be retained by the hospital or attending physician. Co	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiens prior to burial, cremation, or removal.	vent, the medical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 13	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exect	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fur be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

	FOR STATE REGISTRAR	STATE OF MARYLAND / I		OF HEALTH AND I	MENTAL HYGIENE REG. NO.		
	1. OECEOENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH DAY	VEAD	3. TIME OF DEATH
	HERMAN	Lytle			4 4	93 YEAR	12:12 A M
	578037195 1	SEX 8. AGE (In yrs. lest)	YRS. IF UNDER 1	YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Month, JDay, Year)	6. BIF	ITHPLACE (State or Foreign intry)
E	98. FACILITY NAME (If not institution, give street  Regency	and number)	96. CITY,	TOWN OR LOCATION OF OR	HTA	COUNTY OF	OEATH
6	RESIDENCE OF DECEDENT		170	-of water	'-/		
FUNERAL DIRECTOR	10a, STATE 10b, COUNTY		10c. CITY, TOWN OF	LOCATION			10d. INSIDE CITY LIMITS?
0		George's	Foresty				1 X YES 2 NO
34	10e. STREET AND NUMBER			10f. ZIP CODE	1	log. CITIZEN O	F WHAT COUNTRY?
N N	7420 Marlboro Pike			20747		U.S.	
BY FU	11. MARITAL STATUS  1	P. WAS DECEDENT EYER IN U.S. ARM FORCES? 1 XYES 2 NO IF YES, GIVE WAR OR DATES DEC. 1942	) If	AS DECEMBENT OF HISPAI yee, epecify Cuben, Mexica XYES 2 NO Specif	IIC ORIGIN? (Specify Yes or in, Puarto Rican, etc.) y:	BI	NCE — American Indian, eck, White, etc. ec/ly: BLACK
	15. DECEDENT'S EDUCAT	ION 16a, DEC	EDENT'S USUAL OC	CUPATION	16b. KINO OF BUSIN		
E	(Specify only highest grade con Elementary/Secondary (0-12)	npleted) (Giv College (1-4 or 5+)	e kind of work done d Do NOT use retired.)	ring most of working			
립	12th		intenance	Tech	Self	-Emplo	yed
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				ME (First, Middle, Melden Su	mame)	
BE C	Truman Lytle			Unol	tainable		
	19a. INFORMANT'S NAME (Type/Print)	19b.	MAILING ADDRESS	(Street and Number or Flurel	Route Number, City or Town,	State, Zip Code)	
2	Keith P. Lytle/son	2	010 Savar	mah Pl.,S.I	E. Wash.,DO	20020	)
	20a. METHOD OF DISPOSITION  \$577Burial 2 □ Cremation 3 □ Remova	from State other plac	00)	ne of cemetery, crematory or		TION — City or	
	1 ☐ Burlel 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)			onal Cemeter		rel, N	
	21. SIGNATURE OF EUNERAL SERVICE LICEN		22. N	obert G. Mas	son Funeral	Home,	Inc.
	Hulenit	Temmina	1.		e Road, S.E.		
CERTIFICATION	IMMEDIATE CAUSE (Fine) disease or condition resulting in death) a	DUE TO (OR AS A CONSECUENT OF AS	UENCE OF):	so andary pr	evirm Cerebra	l vascus	Interval Between Onset and Death
PHYSICIAN: MEDICAL C	PART II. Other significant conditions of	ontributing to death but not re	eulting in the un	Jerlying cause given in	Part I. 24a. WAS AN AI PERFORM 1 YES 2 0	ED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
¥	25. WAS CASE REFERRED TO MEDICAL			26. PLACE OF OEATH (C)	neck only one)		
Sic		IOSPITAL:	DOA 4 NI NUT				
ВУ РНУ	27. MANNER OF DEATH  1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE HOW INJ	URY OCCURED	
	2 Accident investigation 3 Suicide 6 Could not be determined	28e. PLACE OF INJURY — At hor building, etc. (Specify)	ne, ferm, street, fact	ry, office	281. LOCATION (Street and City or Town, State)	d Number or Ru	ral Route Number,
COMPLETED	and and	N: To the best of my knowledge, dea On the basis of examination and/or is					se(s) and manner as stated.
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER WILLIAM J. A	end mo		29c. LICENSE NU		29d. DATE SIGN	NED (Month, Day, Year)
-	30. NAME AND ADDRESS OF PERSON WHO CO	ANNER MD		ivington R	20AD. Fut WA	eningt	on, mo
	APR 08 1993	32 REGISTRAR'S SIGNATURE					6

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LAIN. THE IGN ICQUIES II	tificate has been signed	e State Dept. of Health	or Item 23 shows ar	
THE POST INC. OF ALL CHANGE OF THE OWN IS USED THE TOTAL	DIRECTOR: After this cent	yours after death with the	APORTANT: It item 28 is marked, o	
THE ROOT INC	THE FUNERAL (	filed within 72 h	APORTANT: It IS	

93 19909 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MONTH Elizabeth Jane Lamartina 1993 12:15 a 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday)
63 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 212-28-6120 1 M 2 F DAYS 18 1930 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Foxridge Lane 1020 DIRECTOR Baltimore Essex RESIDENCE OF DECEDENT 10e STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY
LIMITS?
1 YES 2 NO Maryland Baltimore FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Hudson Street 6710 21224 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yaa or NoIf yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married COMPLETED BY 1 YES 2 NO Specify 3 Widowed 4 □ Divorced Specify: White 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 8 House Wife Domestic 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surnerr Norman G. Martin BE Esther Wallace 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code 9 Angelo M. Lamartina Emmerick Dr. 1003 Joppatown, Md. 21085 20a. METHOD OF DISPOSITION

Burlai 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Sacred Heart of Jesus 4/10Dundalk, Maryland 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY W. Dabrowski/Chojnacki F. H. P.A. 1005 Dundalk Ave. Balto., Md. 21224 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween IMMEDIATE CAUSE (Final Onset and Death disease or condition\_ w. Jh tdeno Carcinoma resulting in death) DUE TO (OR AS A CONSEQUENCE OF): 10005 CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated evants OUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY 24b, WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMEO? 1 YES 2 NO 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural BY 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 1 ECERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) end menner as stated. (Check only one) 2 MEDIÇÂL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner as stated. 29 LICENSE NUMBER BE 29d. DATE SIGNEO (Month, Day, Year) 11105 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LARRY TLLE Louis O. Olsen 1012 North Point Rd.

Md

DHMH-16 Rev 1/89

Baltimore

31, DATE FILED (Month, Day, Year)

APR 08 1993

32. REGISTRAR'S SIGNATURE

Population

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital on the attending physician and completely filled in by the theory page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, committee, or removal.

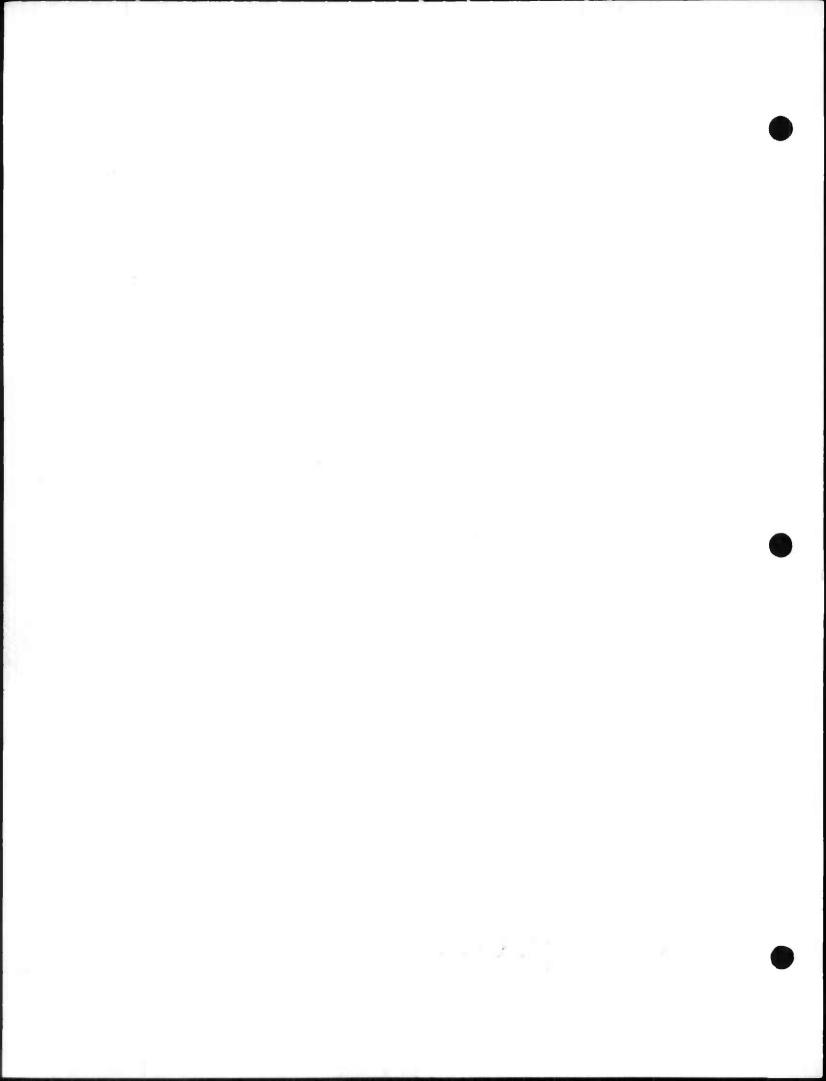
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	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND		NT OF HEALTH AND TE OF DEATH			
	1. DECEDENT'S NAME (First, Middle, Last)		DENTII IOA	IL OF DEATH	REG. NO	).	3. TIME OF DEATH
	FRANK LI	GGON JR.				Q Y	EAR
	4. SOCIAL SECURITY NUMBER	S. SEX 6. AGE (In yrs.	MONTE	DER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8.	BIRTHPLACE (State or Foreign Country)
	214-54-5639  9a. FACILITY NAME (If not institution, give stre-	1 □XM 2 □ F 43	YRS.		10/28/4	9	ALABAMA
œ				TTY, TOWN OR LOCATION OF	DEATH	9c. COUNTY	OF DEATH
CTOR	11 N. HILTON	SIREET (Res.	• /	Baltimore			
DIRE	10a. STATE 10b. COUNTY		10c. CITY, TOW	N OR LOCATION			10d. INSIDE CITY LIMITS?
	Maryland		Ba:	ltimore			1 TYES 2 NO
ERAL	11 N. Hilton S	troot			0	100	OF WHAT COUNTRY?
FUNE		2. WAS DECEDENT EVER IN U.S.	ARMED	2122  13. WAS DECENDENT OF HISP		or No — 14	JSA RACE — American Indian.
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	□но	If yes, specify Cuben, Maxi- 1 YES 2 NO Spec	can, Puerto Rican, etc.)		Black, White, etc. Specify:
0	15. DECEDENT'S EDUCA	TION	DECEDENT'S USUAI		Transition of the same		Black
ETE	(Specify only highest grade co	mpleted)	(Give kind of work do life. Do NOT use retire	ne during most of working	16b. KIND OF BU	SINESS/INDUS	TRY
급		conege (14 or 5 +)					
COMPL	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S N	AME (First, Middle, Malden	Surname)	
BE	Frank Liggon,			Susi	e Jenkins		
TO BE COM	19a. INFORMANT'S NAME (Type/Print)  Mary Liggon			ESS (Street and Number or Rura			
	20a. METHOD OF DISPOSITION	205 81 40	EANDDATEOFDISE	Hilton St.			or Town, Stata
	1 Burial 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	from State Completely	rematory of the pla	natory	1		ille, MD
	21. SIGNATURE OF FUNERAL SERVICE LICEN			LEROY O. DY	ACIUTY COI	T THINK	EDAT HOME
	North	O. Mut	1	4600 LIBERT	ETT & SU	LAUT N	SKAL HOME
	23. PART I Enter the diseases, pr cor	nplicatione that caused the	death. Do not en	ter the mode of dying, su	ch as cardiac or resp	iratory arrest	, Approximata
	IMMEDIATE CAUSE (Fine)	t Dnly Doe cause on each iii	na.	O A			Interval Batweer Onset and Death
	disease or condition resulting in death)	CAST	TIC				
TIFICATION		DUE TO (ON AS A CONTE	MOUENCE OF):	,			
ERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONS	EQUENCE OF):				
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E	thet initiated events resulting in death) LAST	DUE TO (OR AS A CONS	EOUENCE OF):				
E E	d.						
	PART II. Other significant conditions	contributing to deeth but not	t resulting in tha	underlying ceuse given is	Part I. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS
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Σ							1   YES 2   NO
\{	25. WAS CASE REFERRED TO MEDICAL						
<u> </u>	EXAMINER?	OSPITAL:	ОТН				
≚	27. MANNER OF DEATH	☐ Inpatient 2 ☐ ER/Outpatient  28s. DATE OF INJURY	28b. TIME OF	1 28c. INJURY AT	8 Other (Specify) 28d. DESCRIBE HOW I	NJURY OCCUR	FD
ВУ РЬ	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	WORK? 1 YES 2 NO			
	3 Suicide 8 Could not be	28s. PLACE OF INJURY — At I building, etc. (Specify)	home, farm, street, t	actory, office	28t. LOCATION (Street and City or Town, State)	and Number or F	Bural Route Number,
ETE	4 Homicide detarmined				Sily of rown, State)		
		N: To the best of my knowledge,					
O BE COMPL	2 MEDICAL EXAMINER:	On the basic of examination end/o	r investigation, in m	y opinion, death occured at th	e time, date end piece, an	d due to the ca	ruse(e) and manner as stated.
BE	296. SIGNATURE AND TITLE OF CENTIFIEN	2 / Pa 01	MI	29% LICENSE MI	MINER TAR	29d. DATE SA	SHED MOUNTS for Your
2	30 NAME AND ADDRESS OF PERSON WHO C	UNEW VI	1914	1110	100	- 4	1/1/2

2 REGISTRAR'S SI

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	signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Panes 1, 2, should		
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IN THE MUSICIAL OR ALLENDING PR	TO THE FUNERAL DIRECTOR: After this	be filed within 72 hours after death	MPORTANT: If Item 28 Is marke
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. AKA Frances 2. DATE OF DEATH MONTH DAY 3. TIME OF DEATH Francesca J. Maxwell April 1993 6:15 A 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) March 1, IF UNDER 1 YEAR IF UNDER 24 HRS. 1 - M 2XXF HOURS 219-16-8896 YRS 68 1925 Maryland 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 3414 Ramona Ave. Baltimore RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 100 CITIZEN OF WHAT COUNTRY 3414 Ramona Ave 21213 U. S. A. 12. WAS DECEDENT EVER IN U.S. ABMED FORCES? 1 YES 2 2NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. If yee, specify Cuben, Mexicen, Pu 1 YES 25 7NO Specify: 1 Never Married 2 Merried В IF YES, GIVE WAR OR DATES 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEOENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5 +) na na Seamstress Gann Corporation 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) Joseph Sortino Ameda Butera 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2 Marilyn C. Petro (Dghtr) 3414 Ramona Ave., Baltimore, Md. 21213 20e. METHOD OF DISPOSITION
1 | Burlel 2 | Cremetton 3 | Removal from State
4 | Donation 5 | Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE emetery, crematory or other place)
Greenmount Crematory Baltimore, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home 3331 Brehms Lane, Baltimore, Md. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata ehock, or haart failure. Liet only one ceuse on each line. interval Batween IMMEDIATE CAUSE (Final **Onset and Death** disease or condition Arterios clirotie Cardiova cullar Disease resulting in death) QUE TO (OR AS A CONSEQUENCE OF) OPD CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted events DUE TO (OR AS A CONSEQUENCE OF): reaulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE 1 | YES 2 | NO 1 TES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF OEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 YES 2 NO me 5 Residence 6 Other (Specify) 4 🗌 Nurs 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Yeer) 26b. TIME OF 28c, INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 5 Pending investigation 1 Natural 1 YES 2 NO BY 2 Accident 26e. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED 4 Homicide 29e. CERTIFIER

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(C COMPL 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) end menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) D35082 am 93 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

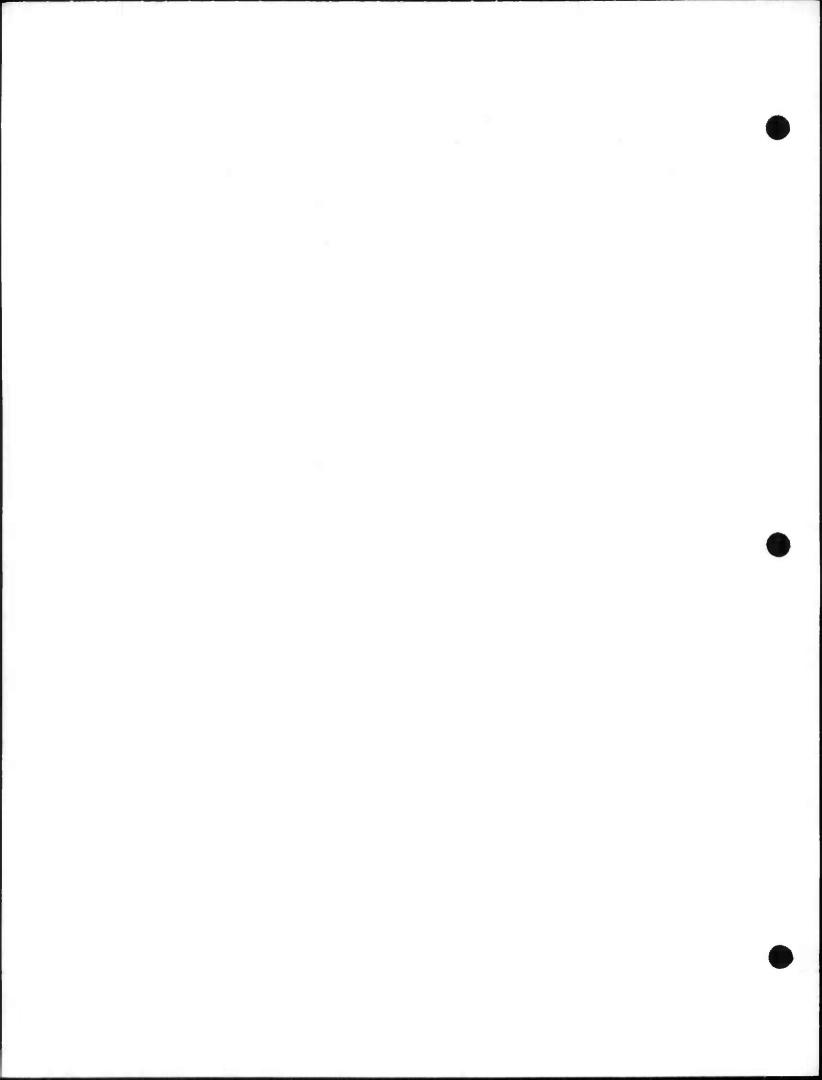
Ramesh, 3400 Erdman Ave., Baltimore, Md.

32. REGISTRAR'S SIGNATURE



Dr. Shanti

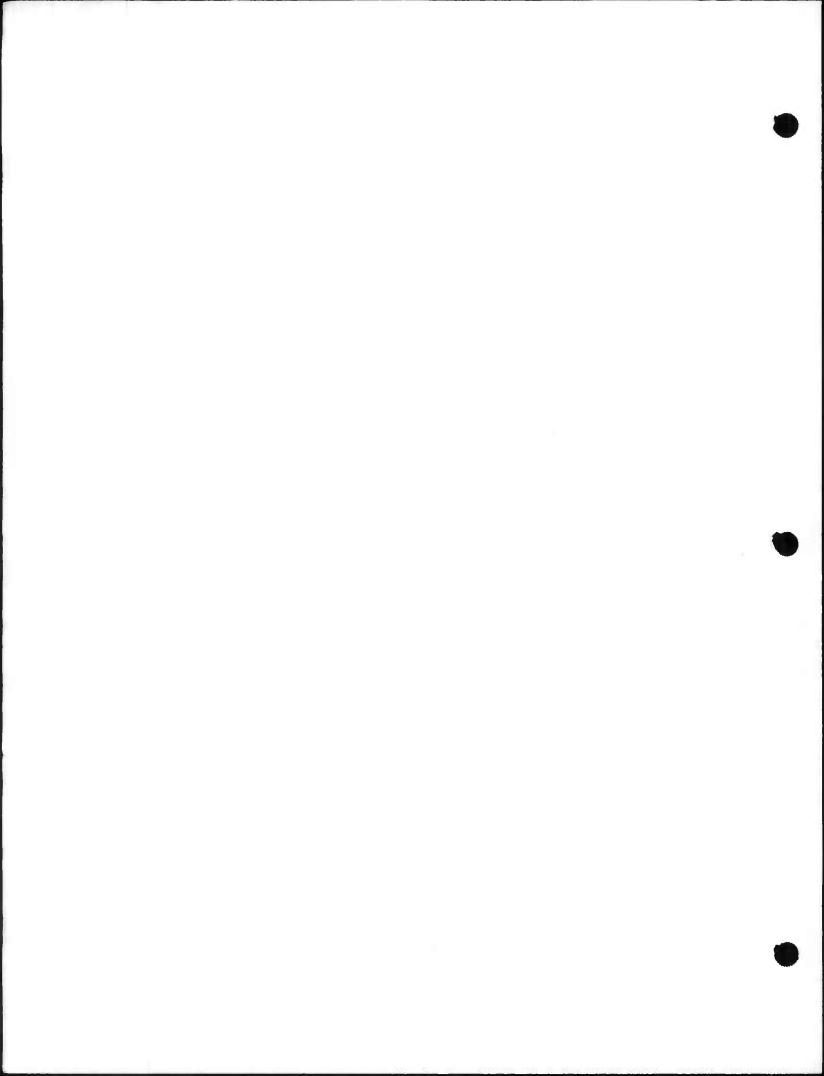
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	REGISTRAR		CERTIF	ICATE	JE DEALD	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)	TN	10 R m	AN		2. DATE OF DEATH DAY YEAR 3. TIME OF DEATH				
- 3		GE (In yrs. lest birthday)	IF UNDER 1 YE	AR IF UNDER 24 HRS.	7. DATE OF BIRTH B. BIRTHPLACE (State or Foreign					
		5. SEX 6. A	87 YRS.	MONTHS DA		(Month, Day, Year)	5	MARYLAND		
- 6	9e. FACILITY NAME (If not institution, give street and number)			9b. CITY, TO	WN OR LOCATION OF DE	EATH	9c. COUN	NTY OF DEATH		
œ	CHURCH HOSPITA		RAT	IMORE CI	rπ·∇′					
임	RESIDENCE OF DECEDENT		DAII.	LIMONE CI	-11					
	10e. STATE 10b. COUNTY	10c. CIT	Y, TOWN OR L	DCATION			10d. INSIDE CITY			
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41	10e. STREET AND NUMBER			101. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?				
띪	818 S. ROSE S	TREET			21224			USA		
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B⊀	3 Widowed 4 Divorced			1	A ITO Spoon	,		WHITE		
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COMPLETED	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maiden	Sumame)			
8	JOHN MORMAN				JO ANI					
	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (St	reet end Number or Rural	Route Number, City or Tow	n, State, Zip	Code)		
2	MR. RONALD MORM	AN	8821	GOLDE	N TREE L	ANE BALTO	). M	D. 21221		
1	20m_METHOD OF DISPOSITION		20b. PLACE OF DISPO		of cemetery, crematory or			City or Town, State		
	1 🗹 Buriel 2 🗆 Cremetion 3 🗆 Remov	al from State	other place)	ED (c	CHWARTZI	S)4-5 BAL	TO D	MD		
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	23. PART I. Enter the diseases, or co	The same of the sa								
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F	resulting in death) LAST									
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7	PART II. Other significant conditions	contributing to dea	th but not resulting	In the under	lying cause givan In	Part I. 24a, WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
EDICAL	deples					1 _ YES 2		COMPLETION OF CAUSE OF DEATH?		
	Acute	Noval	Forte	he				1 YES 2 NO		
Σ						— I		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
Z										
PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:	8. PLACE OF DEATH (C/	neck only one)				
S		1 Inpatient 2 I ER	Outpatient 3 DOA		Home 5 - Residence	8 - Other (Specify)				
Ĭ	27. MANNER OF DEATH	28e. DATE OF INJU		AE OF 28	L INJURY AT WORK?	28d. DEŞCRIBE HOW	NJURY OC	CURED		
	1 Natural 5 Pending	(			YES 2 NO					
ВУ	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF IN.	JURY — At home, farm,	street, factory,	office	28f. LOCATION (Street	and Number	r or Rural Route Number,		
Ë	4 Homicide determined	building, etc.	(Specify)			City or Town, State				
COMPLET	290. CERTIFIER					1				
린	(Check only					e to the cause(e) end me				
0	2 MEDICAL EXAMINER	On the basie of examin	nation end/or investigati	on, in my opini	on, death occured at the	ilme, date end place, er	d due to It	he couse(e) and manner so stated.		
	29b. SIGNATURE AND TITLE OF CERTIFIER		0 1	0 1. 7	29c. LICENSE NU	MBER	29d. DAT	E SIGNED (Month, Day, Year)		
8	) doverno zu	/ feed	· Jello	UH	040	356	1 5	4/1/93		
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE O	DEATH (ITEM 27) (Ton	e, Print)		A A		, , -		
	RI NAVARRO	100 N	Broad	way	n Ba	356 en-MD	21	123/		
	APR 08 1993	32. REGISTRAR'S	Adaptive							

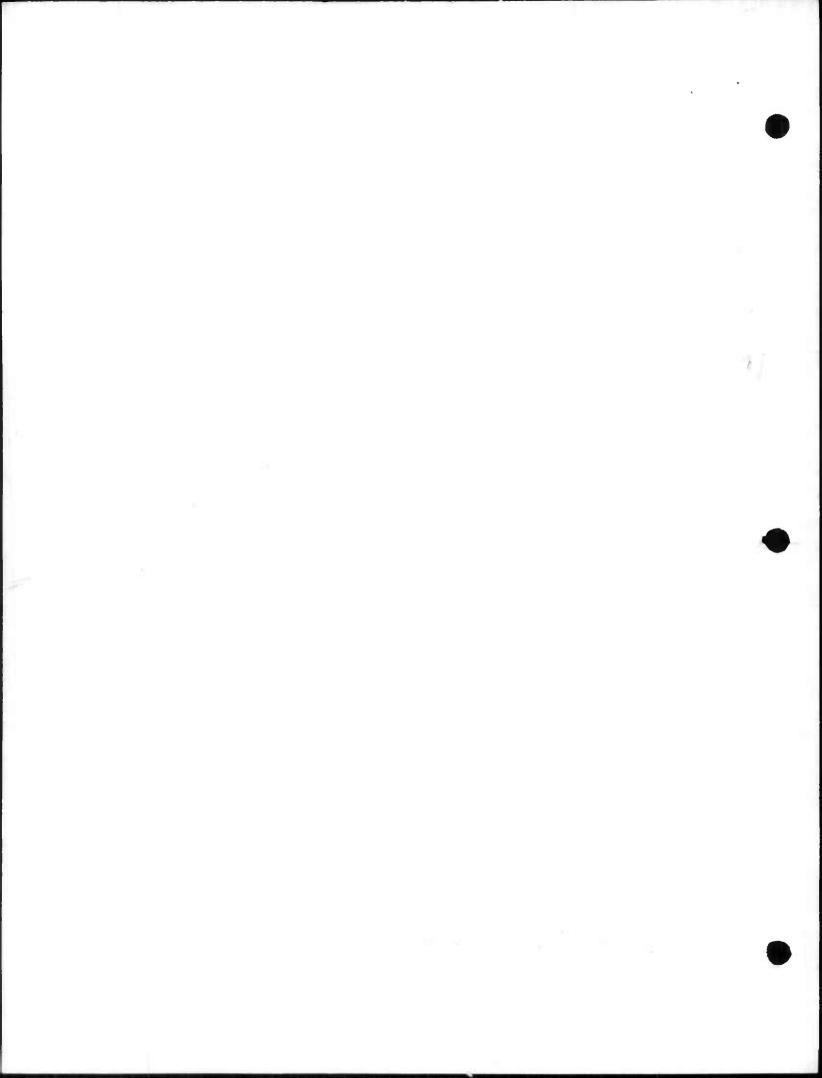


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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 22 Figures after death. Page 6 may be retained by the hospital or at	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: if Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
4	-	_	-1

Dr. Boon lim
31. DATE FILEO (MONTH, P.S. 1993)
APR - 8 1993

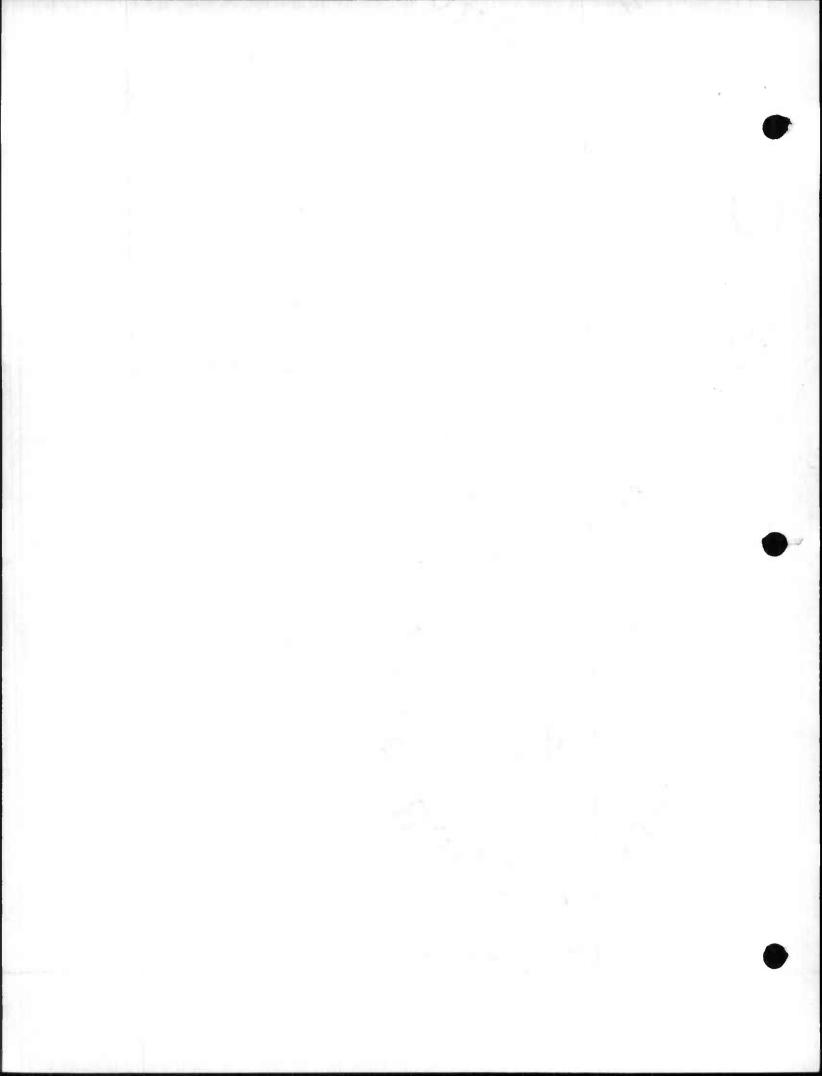
	FOR Y - STATE REGISTRAR	STATE OF MAR					HEALTH AND	MENTAL	HYGIEN	_	93	09913
	1. DECEDENT'S NAME (First, Middle, Last)						BEATT	2. DATE	OF DEATH			3. TIME OF DEATH
	Mildred Elaine					MONT	-2-93	AY	YEAR	3. TIME OF DEATH P		
	4. SOCIAL SECURITY NUMBER	5. SEX 6. A	NGE (In yrs. les				7. DATE	DATE OF BIRTH S. BIRTHPLACE			PLACE (State or Foreign	
	220-12-4344 1 M 2 7 F 68			YRS.	MONTHS	DAYS	HOURS MIN.	(Month, Day, Year) Country			1)	
	Se. FACILITY NAME (If not institution, give street and number)				9b. CIT	Y, TOWN	OR LOCATION OF D	EATH	0/74	9c. COUN	TY OF DE	timore
FUNERAL DIRECTOR	Franklin Square Hospital				Baltimore					Baltimore		
#	10a. STATE 10b. COUNTY				Y, TOWN	OR LOCA	TION		10d. INSIDE CITY			
ā	Maryland Balti	more		Pe	rry	Hal:	1					1 TYES 2 X NO
.¥	10e. STREET AND NUMBER					10	f. ZIP COOE			10g. CITIZ	EN OF W	HAT COUNTRY?
<b>"</b>	5316 Silverspring	Rd.					21228			U:	SA	
BY FU	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EV FORCES? 1 1 1	rES 2 X N	MED IO	13.	If yes, sp	CENDENT OF HISPAI Hecity Cuban, Mexica 2 X NO Specific	an, Puerto R	? (Specify Yes lican, etc.)	or No	14. RACE Black, Specif	- American Indian, White, etc. y:
	Χ	<u> </u>										White
COMPLETED	15. DECEDENT'S EDU- (Specify only highest grade Elementary/Secondary (0-12)	Cation completed)  College (1-4 or 5 +)	(Gi life.	Do NOT us	work done e retired.)	during me	ost of working	16b.	KIND OF BUS	SINESS/INDU	JSTRY	
M			Con	pute	r Or	erat			rank (		& S	ons
	17. FATHER'S NAME (First, Middle, Last)						ta. MOTHER'S NA			Surname)		
BE	John H. Cooney  190. INFORMANT'S NAME (Type/Print)						Emma F					
10	James Adams						oring Rd.		-			
	20e. METHOD OF DISPOSITION 1) Burlel 2 Cremetion 3 Rem	oval from State	20b. PLACE	NDDATE	OF DISPO	SITION (N	ame of	DATE		CATION — C		vn, State
	1) Burial 2 Cremetion 3 Ram 4 Donation 5 Other (Specify)		Garde	ns o			Cem. 4/		Ba	altimo	ore,	Md.
	21. SIGNATURE OF FUNERAL SERVICE LIC	unoral	dem	0.			nd address of Fa ahn Funer Belair F		ome alto	Md.	2123	36
	23. PART I. Enter the diseases, or o	complications that cau	used the de	eth. Do r	ot ente	r the mo	de of dying, suc	h as card	lac or respi	ratory arre	st,	Approximate
	shock, or heart fellure. List only one cause on each ilns.								Intarval Between Onset and Death			
		UENCE O	E OF):									
NO	Sequentielly list conditions,		Chronic Obstructive pulmonary disease									
¥	if any, leading to immediate cause. Enter UNDERLYING		Congestive heart failure  Due to (or as a consequence of):									
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	AS A CONSEC	MSEQUENCE OF):									
S		d										1
¥	PART II. Other significent condition	a contributing to deal	th but not n	suiting	in the u	nderlyln	g ceuse given in	Part I.	24a. WAS AN			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
음	PERFORMED? AMAILABLE PI  T VES 2 NO OP DEATHY:								COMPLETION OF CAUSE OF DEATH?			
뿔										X		1 YES 2 NO
ä												
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one)											
PHYSICIAN: MEDICAL	1 YES 2 NO	1 _ Inpatient 2 _ ER/	Inpstient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6						(Specify)			
ВУ РН	27. MANNER OF DEATH  1 \( \text{Netural} \) S \( \text{Pending} \) Pending 2 \( \text{Accident} \) Accident Investigation				8b. TIME OF INJURY AT WORK?  M 1 YES 2 NO			28d. DEŞCRIBE HOW INJURY OCCURED				
	2   Accident 3   Suicide 6   Could not be determined   28e. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify)						281. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC DESCRIPTION OF	CIAN: To the best of my k										end manner as stated.
	296. SIGNATURE AND TITLE OF CERTIFIER						29c. LICENSE NUR					
TO BE	296. LICENSE NUMBER N/A  296. LICENSE NUMBER N/A  296. DATE SIGNED (Month, Day, Year)  4-2-93											

Franklin Square Dr. Baltimore, Md. 21237



i examiner must be notified at once	IMPORTANT: If hem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once
the funeral director, page 5 should be detached	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached he find within 72 hours after death with the State hand of Heath and Mental Houlene prior to havin communation or named.
er death. Page 6 may be retained by the hospi	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospi

	FOR STATE REGISTRAR	STATE OF N			RTMENT O			MENTAL HYGIEN		93	09914
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATH			TIME OF DEATH
1	Charles E.	Mall						монти с	4	EAR S	635 P M
	4. SOCIAL SECURITY NUMBER 218-26-3771	5. SEX 1 M 2 F	6. AGE (In yrs.	last birthday) YRS.	MONTHS DAVE MOURE MAN			7. DATE OF BIRTH (Month, Day, Year)	33	Country)	ACE (State or Foreign
H.	98. FACILITY NAME (II not institution, give street end number)  96. CITY, TOWN DR LOCATION OF DEATH  Sa. OT JOSEPH HOSPITA  BALTIM										
5	RESIDENCE OF DECEDENT										
DIRECTOR	Maryland Harf	16c, CIT	Belaij			10d. INSIDE CITY LIMITS? 1 YES 2 NO					
뒫	10e. STREET AND NUMBER				DOTOT	101. ZIP CO		T COUNTRY?			
FUNERAL	306 Idlewild Rd.					2	1014		U	SA	
5	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S.	ARMED	13. WAS	DECENDENT	OF HISPAI	NIC ORIGIN? (Specify Ye	s or No—	14. RACE —	American Indian, /hite, etc.
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE Y		<b>3</b>	1 🗆	YES Z N	Specif	nn, Puerto Rican, etc.) y:		Specify:	
	15. DECEDENT'S EDUC	CATION	1 100	DECEDENT	USUAL OCCU	ATION		Lan amin de en			White
	(Specify only highest grade Elementary/Secondary (0-12)	completed)		(Give kind of the Do NOT u	work done durin se retired.)	most of wor	king	16b. KIND OF BU	SINESS/IND	USTRY	
COMPLETED	12th grade	College (1-4 or 5	•)					tor Md.Sch	ool f	or th	e Blind
8	17. FATHER'S NAME (First, Middle, Last)							ME (First, Middle, Maider			
	Leo Marr							Wilson	,		
BE (	19e. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS (St	et and Numb	er or Rurat	Route Number, City or Tox	vn, State, Zip	Code)	
2	Marlene C. Marr							air , Md.	2101		
· i	20a. METHOD OF DISPOSITION 1X Buriel 2 Cremation 3 Remote 4 Donation 5 Other (Specify)	oval from State	20b. PLAC	E AND DATE	of DISPOSITIO	Gard	ens (	4-7-93 Bel	cation —	City or Town,	State
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	1001 /	111		E AND ADDE			u,	ridi y i	arra
	Lesseln Fres	wal !	Vone					l Home d. Baltimo	re. m	d. 21	236
	23. PART i. Enter the diseases, or o	omplications the	t ceused the	deeth. Do	not enter the	mode of d	ying, suc	h as cerdiec or resp	iratory arr	est,	Approximate
	ahock, or heart failure. I IMMEDIATE CAUSE (Finel disease or condition	Cha			genous	Lei	IKPA	n.a			Interval Between Onset and Daeth
	resulting in death)	DUE TO	(OR AS A CONS	EQUENCE O	7 (1 10 4 )			11			(247)
z	be to (on as a consequence or):										
E	Sequentially list conditions, if any, leading to immediate  DUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	CAUSE (Disease or Injury	£									
Ë	that initisted events resulting in death) LAST	DUE 10	(OR AS A CONS	EOUENCE O	<b>№)</b> :						
8		d									
	PART ii. Other significant condition	a contributing to	death but no	resulting	in the under	ying ceuse	given in				RE AUTOPSY FINDINGS
5	PERFORMED?								CC	AILABLE PRIOR TO DMPLETION OF CAUSE DEATH?	
Ä											YES 2 NO
z I											_
M	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				2	. PLACE OF	DEATH (Ch	eck only one)			
Š	1 YES 2 NO	HOSPITAL:	ER/Outpetient	3 DOA	OTHER: 4 Numing	Home 5 🗆	Residence	6 Other (Specify)			
Y PHYSICIAN: MEDICA	27. MANNER OF DEATH  1 Netural 5 Pending	28a. DATE OF (Month, D		28b. TIN	JURY	INJURY AT WORK?	□ NO	28d. DESCRIBE HOW	INJURY OCC	URED	
ED BY	2 Accident Investigation 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify)  28f. LOCATION (Street and Number or Rural Route Number, City or Yown, State)										
9	29e. CERTIFIER				11-2-1						
COMPLETED	29e. CERTIFIER (Check only one)  1 CERTIFIND PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner as stated.  2 MEDICAL EXAMINER: Dn the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and menner as stated.										
BE	29b. SIGNATURE AND TITLE OF CERTIFIER  29c. LICENSE NUMBER  29d. DATE ROPED (Married)								One Year)		
유	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	SE OF DEATH (1)	EM 27) (Type	, Print)			001		111	1
	A, Krasner	767	V Yo	TK	Prac	To	ng	n, MD	212	04	
i	31. DATE FILED (Month, Dey, Year)  APR = 8 1993	Julia D	WILDON-A	andelle	3 1						
		0	to april	-							DHMH-16 Rev 1/89



TO THE POSSIVEL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE PUNERAL PIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filso-being after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

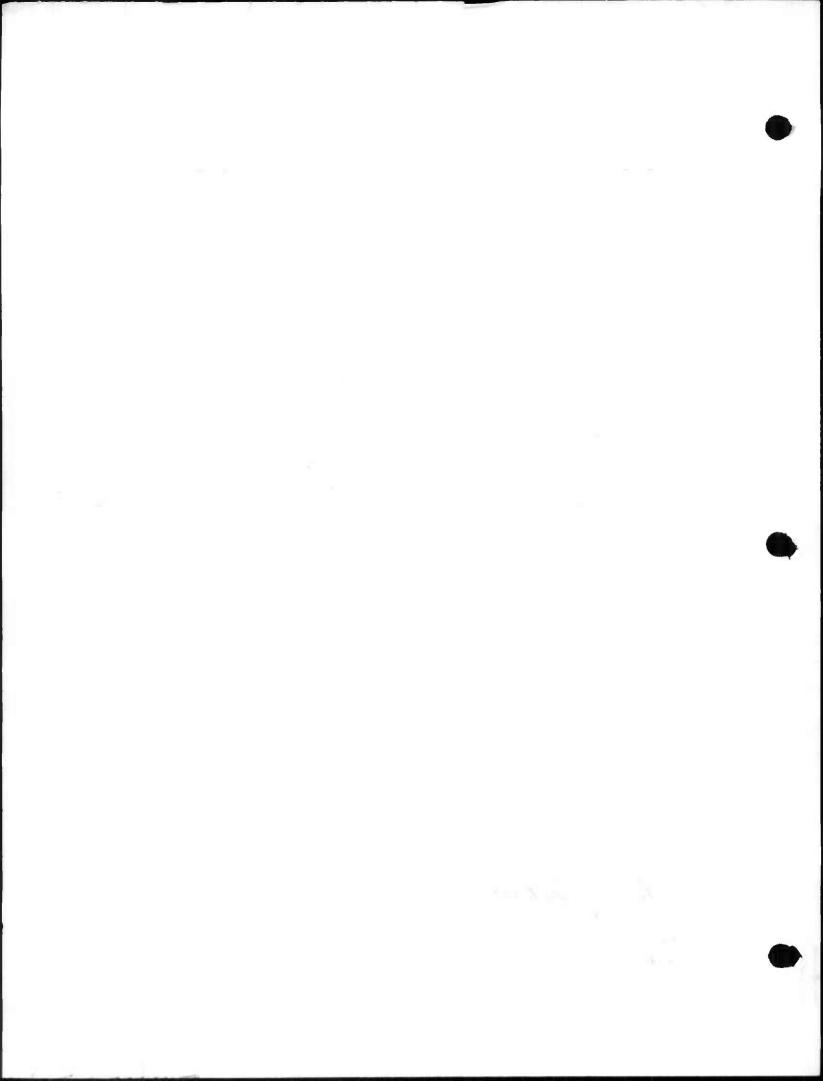
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CE	RTIFIC	CATE OF	DEATH		REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)							OF DEATH	121		3. TIME OF DEA	TH
3	ROMAN	JOHN			MORGE	RETH	0 4		04	93	3:20	PM
1	4. SOCIAL SECURITY NUMBER	5. SEX (	8. AGE (In yrs. las		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE C	OF BIRTH			PLACE (State or F	
1	218-18-2813	1 J M 2   F	83	YRS.	ONTHS DAYS	HOURS MIN.	(Month,	Day, Year) - 22-1	909	Country	"Maryla	nd
	Se. FACILITY NAME (If not institution, give a	treet end number)			9b. CITY, TOWN	OR LOCATION OF D				NTY OF DE		, , , , ,
8	700 S PONCA ST	rprrm			PAITT	MORE CI	TV					
5	700 S. PONCA ST				DALLI	TORE CI	11					_
2	10e. STATE 10b. COUNTY	Y		10c. CITY,	TOWN OR LOCA						10d. INSIDE CIT	γ
	Maryland					Bal	timor	e			1 [ YES 2 [	NO
₹ I	10e. STREET AND NUMBER	0.1			10	1. ZIP CODE		-	-		HAT COUNTRY?	
FUNERAL DIRECTOR	700 South Ponc						21224			Unit	ed Stat	es
5	11. MARITAL STATUS  1 X Never Married 2 Merried	12. WAS DECEDENT FORCES? 1	EVER IN U.S. ARI	MED		CENDENT OF HISPA			or No-	14. RACE Black	- American Ind White, etc.	len,
BY	3 Widowed 4 Divorced	IF YES, GIVE WAI	R OR DATES			2 NO Speci		our, orday	ļ	Specif	V	. 1
	15. DECEDENT'S EDU	CATION II	Army								White	2
COMPLETED	(Specify only highest grade	completed)	(G/	ve kind of wo Do NOT use	SUAL OCCUPATI rk done during m	ON ost of working	16b.	KIND OF BU	SINESS/IND	USTRY		
7	Elementary/Secondary (0-12)  1.0th. Grade.	College (1-4 or 5+)	2001		nance			Amari	oan (	Stanc	lard Co.	
N	17. FATHER'S NAME (First, Middle, Last)		IAI	urne	nance	16. MOTHER'S NA	NAS (Since A)			Sturio	iwia co.	
	Joseph Herman Mo	anaanath				Ursula			,			
8	190. INFORMANT'S NAME (Type/Print)	origeren	101	MAILING A	DDBESS /Street	and Number or Aural				0.11		
임	Francis J. Morg	onoth				e Drive					nd 212;	37
	204, METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remo				DISPOSITION			20c. LO				77
	1 Donation 5 Other (Specify)	oval from State	cometery, cres	natory or othe	orest (						S, MD	
1	21. SIGNATURE OF FUNERAL BERVICE LIC	ENSEE	1 000000	2011								
	1				Duda-	ND ADDRESS OF FA	ieral	Home	06 DI	undal	ck, Inc.	
$\rightarrow$	of part course	-			7922	Wise Ave	enue	Dunda	lk, I	Maryl	and 21	222
	23. PART I. Enter the diseeses, Dr o shock, Dr heart fallure.	List only one cause	e on each iine.	atn. Do no	t enter tha mo	de of dying, aud	ch ae cardi	ac Dr reapi	ratory arr	ast,	Approxim	
	IMMEDIATE CAUSE (Final disease or condition										Onset and	
	-Arteriosclerotic Cardiovascular Disease  Due TO (OR AS A CONSEQUENCE OF):											
		DUE 10 (0	R AS A CONSEC	UENCE OF):								
CERTIFICATION	Sequentially list conditions,  DUE TO (OR AS A CONSEQUENCE OF):											
Ă	if any, leading to immediate cause. Enter UNDERLYING											l
윤	CAUSE (Disease or injury that initieted events	DUE TO (O	R AS A CONSEC	UENCE OF):							-	
E	resulting in death) LAST	4										
	DADY II Other significant and district											
₹	PART II. Other eignificant condition	s contributing to de	eath but not re	eulting in	the underlyin	g ceuse givan in	Pert i.	24a. WAS AN PERFOR			WERE AUTOPSY F	
ă								1 TES Z	XNO.		COMPLETION OF ( OF DEATH?	CAUSE
Σ								INOU	JIRY		1   YES 2	NO
ž												
힐	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			THED.	ACE OF DEATH (Ch						
BY PHYSICIAN: MEDICAL	1 X YES 2 NO	1 Inpatient 2 E		□ DOA 4	☐ Nursing Hon	e 5 Residence	_					
	1 Natural 5 Pending	28a. DATE OF IN (Month, Day,		28b. TIME	TY WC	URY AT	28d. DE\$0	RIBE HOW I	NJURY OCC	CURED		
8	2 Accident Investigation	20. 81 105 05				rES 2 NO						
	3 Suicide 8 Could not be 4 Homicide determined	building, etc	INJURY — At hor c. (Specify)	ne, ferm, atr	eet, factory, offic	•	281. LOCA City or	TION (Street e Town, Stete)	and Number	or Rural Ro	oute Number,	
E I	29a. CERTIFIER						<u> </u>					
COMPLETED	(Check only	CIAN: To the best of m	y knowledge, des	th occurred	at the time, date	end place, end dua	to the caus	e(a) end mar	mer ae state	ed.		
į	one) 2 MEDICAL EXAMINE	R: On the beals of exar	mination end/or in	westigation,	In my opinion, o	eath occured at the	time, date e	nd place, en	d due to the	e ceuse(e)	end menner ee s	tated.
BE (	296. SIGNATURE AND TITLE OF CERTIFIER					29c. LICENSE NUI	MBER		29d. DATE	E SIGNED (	Month, Day, Year)	
2	Dermis/fills	ent in				O.C.M.	Ε.		▶ 4	-5-1	.993	
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE										$\neg$
	DENNIS J.CHUTE			Penn	Stre	et, Bal	timo	re, N	Mary	land	2120	01_
	31. DATE FILED (Month, Day, Year) APR 08 1993	32, REGISTRAR'S										
	TOD 110 1005	C. K. Tanil.	- Rando B	9								- 1

DHMH-16 Rev 1/89

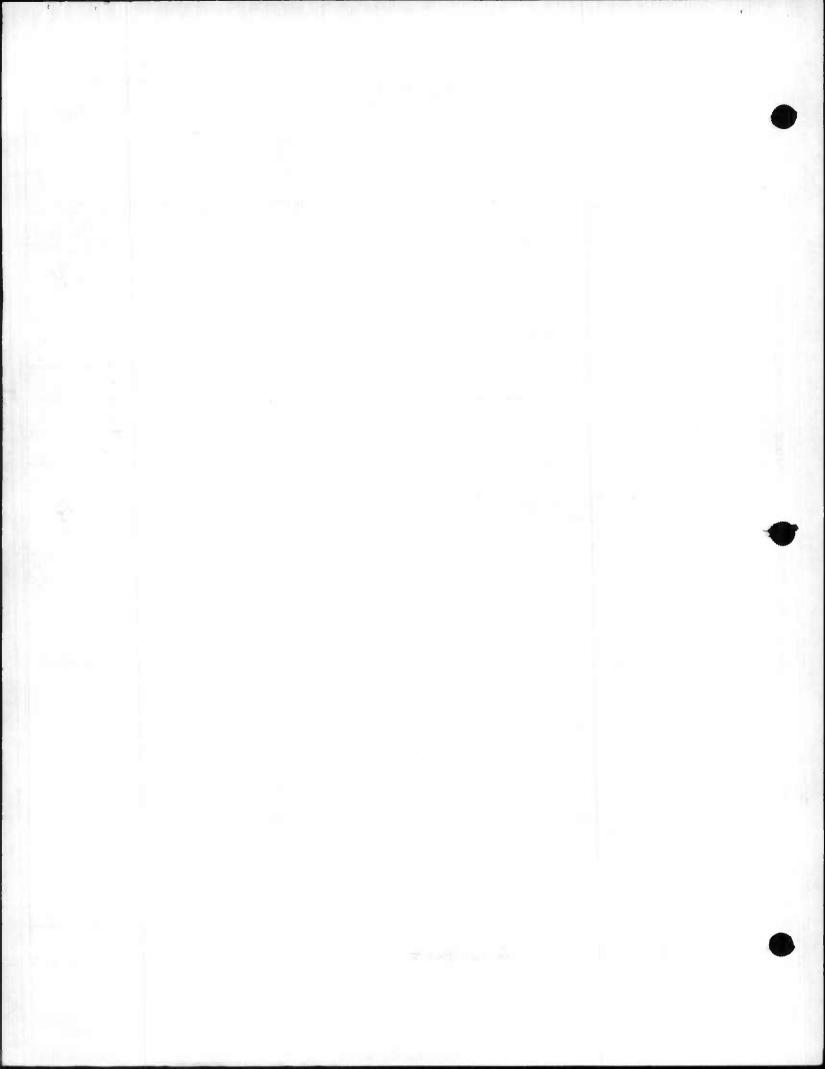


FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

	James :	(1)	ARNER	AV		P p	CD	2. DATE OF	DA		PRAN	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBE		5. SEX	6. AGE (In yrs. In		DER t YEAR	IF UNDER 24 HRS.	7. DATE OF			3 BIRTHPI	LACE (State or Foreign
	251-26-671	7	1)( M 2   F	7.0	YRS. MONTH	B DAYS	HOURS MIN.		Day, Year)		SOU	
	9a. FACILITY NAME (If not Inst		street and number)	70	96. C	ITY, TOWN	OR LOCATION OF D		2-192	9c. COUNT		
S S		1ed	Ical Ce	nter	P	Salt	more					
DIRECTOR	RESIDENCE OF DECE	10b. COUNT	Y		10c. CITY, TOW		The state of the state of					IOd. INSIDE CITY
듬	MD.				В	ALTI	MORE CI	TY				LIMITS?
A	10e. STREET AND NUMBER						1. ZIP CODE			10g. CITIZE		IAT COUNTRY?
EB	1622 W. LAFA	YETTI	E AVENUE				21217			US	A.	
FUN	11. MARITAL STATUS 1 Never Married 2 M	lerrlad	12. WAS DECEDENT FORCES? 1	YES 2	RMED 1	3. WAS DEC	CENDENT OF HISPA	NIC ORIOIN?	(Specify Yes	or No-	I. RACE -	- American Indian, White, atc.
BY	3 Widowed 4 Divorc		IF YES, OIVE W	AR OR DATES		1 TYES	2 NO Speci	fy:			Specify:	
	15. DECEI (Specify only i	DENT'S EDU	CATION		ECEDENT'S USUAL			16b. K	IND OF BUS	INESS/INDUS		OK
	Elementary/Secondary (0-1		College (1-4 or 5+	116.	Sive kind of work do a. Do NOT use retired	ne during mo d.)	ost of working					
L				T	RUCK DRI	VER						
COMPL	17. FATHER'S NAME (First, Mide						18. MOTHER'S NA		idie, Maiden S	Sumama)		
BE	WILLIAM  19a. INFORMANT'S NAME (Typ)		DINE SR.				BESSI		BARN			
임	JoANN	BAXLI	ev.				and Number or Rural					01017
	20e. METHOD OF DISPOSITIO	N			AND DATE OF DISP		ETTE AVE	DATE		CATION - CH		
	1 N Burial 2 Cremation 4 Donation 5 Other (S		oval from State	cemetery cri	emetory or other place	tel les	CEMETERY	1	100	NGS M		
	21. SIGNATURE OF FUNERAL	SERVICELL	CENSEE	A	2	2. NAME AF	ND ADDRESS OF F					
	D(I/Va	1/2	- V.).	Das			H H. BRC					, P.A. P.O. BOX 443
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	ert tsllure.	List only one caus	se on aach line	B.	er the mo	Failure		c or respir	atory arres	t,	Onset and Dest
TIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentisity list condition if any, leading to immediaceuse. Enter UNDERLYIN CAUSE (Disease or injury that initiated events	ns, sta	s. Cong DUE TO DUE TO	OR AS A CONSE	OUENCE OF):	er the mo			c or respir	atory arres		Interval Betwee Onset and Dest
O	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentisity list condition if any, leading to immedia cause. Enter UNDERLYIN CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant	ns, sta	B. DUE TO (  DUE TO (  DUE TO (  DUE TO (  DUE TO (	OR AS A CONSE	QUENCE OF):	er the mo	Failur	Part I. 2	6a. WAS AN A PERFORI	AUTOPSY MED?	24b. W. A. C.	Interval Between Onset and Dest
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BE COMPLETED BY PHYSICIAN: MEDICAL C	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list condition if any, leading to immediate cause. Enter UNDERLYIN CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant Resulting in death) LAST  25. WAS CASE REFERRED TO EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5 Part Immediate Reciden	medical medica	B. DUE TO (  DUE	OR AS A CONSE OR	OUENCE OF):  OUENC	underlying  26. Pt  ER: ursing Hom  28. INJ actory, office	g ceuse given in  ACE OF OEATH (C)  10 5   Residence  11 NO  20 2   NO  and place, and due  20 c. LICENSE NU	Part I. 2.  1 1  1 2  1 2  1 2  1 2  1 3  1 3  1 3	Specify) ON (Street are flown, State) (a) and ment	MUTOPSY MED? NO NO NO NUTRY OCCUP THE NUTRY OCCUP THE SERVED. It due to the c	24b. W A C D 1 1 REO Rural Rou	Interval Between Onset and Dest  C Week,  FERE AUTOPSY FINDINGS MAILABLE PRIOR TO OMPLETION OF CAUSE OF DEATH?  YES 2 NO

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



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ages 1, 2, 3 should

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 Yours after death. Page 6 may be retained by the hospital or attending physician.	FUNEAL DIRECTOR: After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit nermit.	within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	TANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
CIAN: T	ortificate	he Stati	or ite
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AL OR	AL DIR	72 hour	If Hen
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FUNERAL DIRECTOR: After the within 72 hours after dead TANT: If Item 28 is m

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Stephanie Huon 04 1993 6:51 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) DF b. n. Day, h. O/ IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS 1 M 2 PF YRS Md. 03 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH FUNERAL DIRECTOR Square Hospital Rossville Baltimore 10a. STATE 10b. COUNTY 10c. CITY, TOWN DR LOCATION 10d. INSIDE CITY Md. Baltimore Overlea 1 YES 2 NO 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 10f. ZIP CODE 7104 Greenwood Ave. U.S.A. 21206 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Nover Married 2 Married IF YES, GIVE WAR OR DATES В 1 TES 27300 Specify. 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+) Infant 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname)
(harlotte Bolander Paik Hyon BE 19a, INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7/04 Greenwood Ave. Bato., Md. 2/206 2 Hyon Paik 200. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE 1 St Burlai 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) yardens of etory or other place) Overlea, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 6224 Charles S. Zeiler & Son Inc. Eastern Ave. 23. PART I. Enter the diseases, or complicatione that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate shock, or heert fellure. List only one ceuse on each line. Interval Between **IMMEDIATE CAUSE (Finel Onset and Death** disease or condition SUDDEN INFANT DEATH SYNDROME resulting in death) DUE TO (DR AS A CONSEQUENCE OF CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEDUENCE OF): if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (DR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY 1 YES 2 NO OF DEATH? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 5 Pending investigation **Natural** 1 YES 2 ND BY 2 Accident 28e. PLACE OF INJURY — At home, farm, streel, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) E 8 Could not be determined 4 Homicide TO THE HOSPITAL OR ATTY
TO THE FUNERAL DIRECTO
DE filed within 72 hours aff
IMPORTANT: If Item 28 COMPLET 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, end due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis ill end/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and menner as stated, 29). SIGNATURE AND TITLE OF CERT IER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 8 O.C.M.E. 04/04/1993 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

WARIOF BULKE JR 111 Penn Penn Street, Baltimore, Maryland 21201 31. DATE FILED (Month, Day, Year)
ADD 08 1993 32. AGISTRAR'S SUNATURE

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FOR 1 - STATE

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR		CERTIF	ICATE OF	DEATH	REG. NO	J.	
		1. DECEDENT'S NAME (First, Middle, Last) LEON	LAWREN		PETIT		3 MONTH 23	<b>1</b> 99	3. TIME OF OEATH 1:01A
멸		4. SOCIAL SECURITY NUMBER 577-92-5622	1 🔀 M 2 🗆 F 22	in yrs. lest birthdey) YRS.	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 9-12-70		BIRTHPLACE (State or Foreign Country) Wash., D.C.
, 2, 3 should	DIRECTOR	9a. FACILITY NAME (If not institution, give sti  1000 JANSAN AV RESIDENCE OF DECEDENT				OR LOCATION OF O		PRIN	OF DEATH CE GEORGE
les 1,	2	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCA	TION			10d. INSIDE CITY
if. Pages		D.C.		W	ashingto	n			LIMITS?
n. Insit permit.	ERAL	3965 First Street	., S.W.		10	20032		1 -	OF WHAT COUNTRY?
21215-0020 al or attending physician. for use as the burial-transit	BY FUNE	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	If yes, ap		NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)		RACE — American Indian, Black, White, atc. Specify: BLACK
215 attend	回	15. DECEDENT'S EDUC (Specify only highest grade of	ATION completed)	16a. DECEDENT'S	USUAL OCCUPATI work done during me	ON ost of working	16b. KIND OF BU	SINESS/INDUST	
AND 2121 the hospital or attedetached for use once.	COMPLET	Elementary/Secondary (0-12) 12th	College (1-4 or 5+)	IIIe. Do NOT u	cleaner		Sears	& Roeb	uck
the hor detach	00	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Malden		
MARYL stained by should be otified at	BE	Leon Lawrence Pet  19a. INFORMANT'S NAME (Type/Print)	ite,II				Estelle S		
ay be retained page 5 should be notified	2	Carolyn Petite/mo	ther				Route Number, City or Tow I. Wash., I		
MORE age 6 may t director, pag or must be		20a. METHOD OF DISPOSITION VIS Burial 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	rval from State cem	etery cremetory or c	of disposition (Monther place) Memorial			cation - chy Landove	
BALTIMORE, MARYLAND after death. Page 6 may be retained by the hospit by the funeral director, page 5 should be detached noval. cal examiner must be notified at once.	ł	21. SIGNATURE OF TINERAL SERVICE LICE	Hemmin a		Rober		on Funeral		Inc. .,DC 20020
at at		23. PART I. Enter the diseases, or co	omplications that caused	the death. Do					
24 / fille fion,		immediate cause (Final disease or condition resulting in death)	liat only one causa on es	ach lina.	m - 3	8) cl	rest		interval Between Onset and Death
68760, executed within and completely o burial, cremat natic event, t	_	resulting in death)	DUE TO (DR AS A	CONSEQUENCE O	F):		- 01		
a cian pe	CERTIFICATION	Sequentisity list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEDUENCE O	F):				
, P.O. Bo eath certificate attending physi ntal Hygiene pr y, or other t	RTIFIC	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (DR AS A	CONSEDUENCE D	F):				
S, P death ental H ental H	S		•						
IAL RECONDS, P. The law requires that the death of the has been signed by the attend are bept of Health and Mertla them 23 shows any injury, or	EDICAL	PART II. Other significant conditions	contributing to deeth be	ut not resulting	in the underlyin	g ceuse given in	Part I. 24a. WAS AN PERFOR	RMED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
REC require been sign t. of He shown	I: ME						_		TES 2 NO
The law the has ate Depr	SICIAN:	25. WAS CASE REFERRED TO MEDICAL			26. P	LACE OF DEATH (Ch	eck only one)		
VITA NAN: The rtificate h ne State I or Item	S	EXAMINER?  1 TYE8 2 ND	HOSPITAL: 1 ☐ Inpetient 2 ☐ ER/Outp	atient 3 DOA	OTHER: 4 Nursing Hon	ne 5 🗆 Residence	8 Other (Specify)	: PUBI	IC STREET
PHYSIC this ce with the diameter.	ву рну	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28e. OATE OF INJURY (Month, Day, Year) 3 22 10		JURY WO	FURY AT DRK? YES 2 X NO	28d. DESCRIBE HOW I	CT SHO	
TENDI TOR: A after d		3 Suicide 6 Could not be determined	28e. PLACE OF INJURY building, atc. (Spec	- At home, farm,	street, factory, offic	•	28f. LOCATION (Street ( City or Town, State) CAPITOL		ural Route Number, HTS, MARYLAND
등 등 등 등 <b>등</b>	LET	29a. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of my knowle			and place, and due			
THE HOSPITAL THE FUNERAL filed within 72 i	COMPL	one) 2 MEDICAL EXAMINER	t: On the basis of exemination						use(a) and manner as stated.
TO THE HOSPIT TO THE FUNERA be filed within ? IMPORTANT: I	#	296. SIGNATURE NO TITLE OF CERTIFIER	100m			29c. LICENSE NUI	MBER	29d. DATE SIG	GNED (Month, Day, Year)
	٩	30, NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	ATH (ITEM 27) (Type	), Print)				
		APR 08 1993	32. REGISTRAR'S SIGNA						

FOR STATE

REGISTRAR

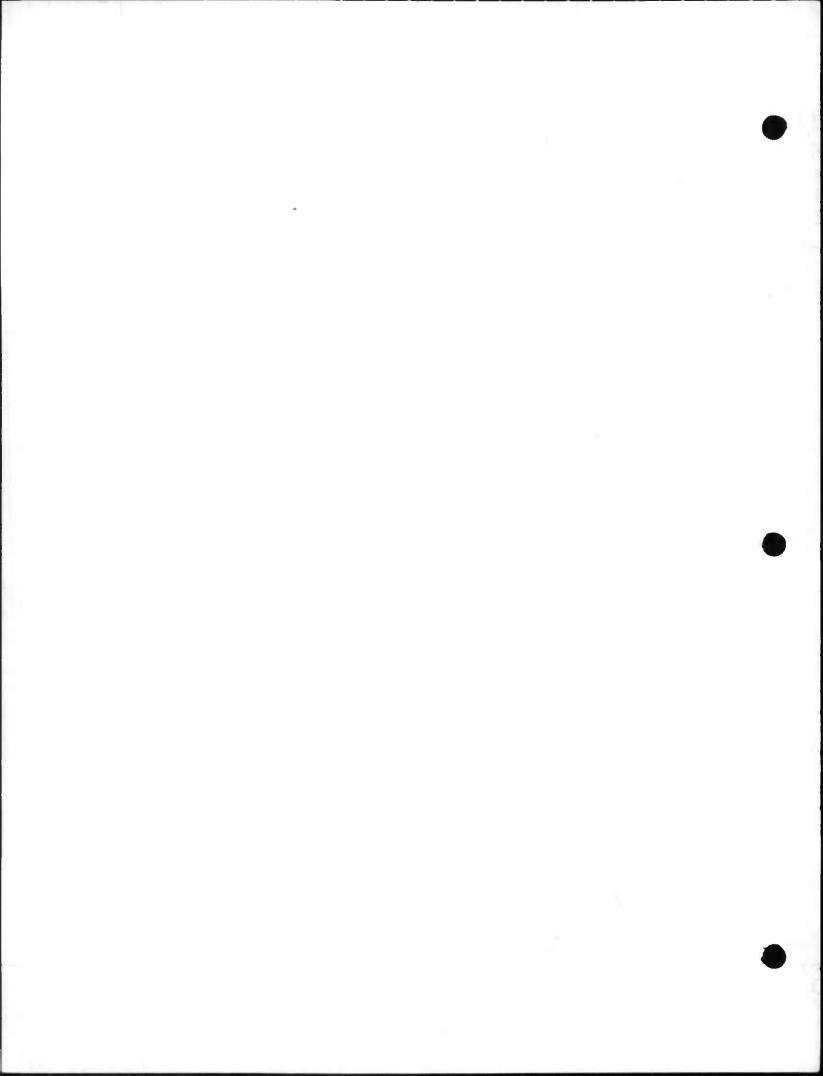
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	AND THE RESIDENCE OF THE PROPERTY OF THE PERSON OF THE PER
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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH PETER ROSTKOWSKI

4. SOCIAL SECURITY NUMBER

5. SEX 7. DATE OF BIRTH (Month, Day, Year) 12-7-11 6. BIRTHPLACE (State or Poreign 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. PENNSYL VANIA DAYS HOURS 1 M 2 F 81 YRS. 9a. FACILITY NAME (If not institution, give street and number) page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR CHURCH HOSPITAL BALTIMORE RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10a. STATE 10d. INSIDE CITY LIMITS? MARYLAND BALTIMORE 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 703 S. MILTON AVENUE 21224 USA 24 nours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 2 XNO 1 Never Married 2 Married Specify: WHITE BY 1 TES 2 NO Specify: 3 Wildowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) CLERK BETH. STEEL 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at ROSTKOWSKI PETRONELLA OLSIEWSKA BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MRS. ELEANOR ROSTKOWSKI S. MILTON AVENUE BALTO. MD. 21224 ě 28e. METHOD OF DISPOSITION
1 O Burlel 2 Cremation 3 R4
Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must has been signed by the attending physician and completely filled in by the funeral director, obet. of Health and Mental Hygiene prior to burial, cremation, or removal. FULLY COCKOSTS POLISH N. C.4-8 BALTO. CO. MD. medicai examiner BIGNATURE OF FUNERAL SERVICE RACZOROWSKI FACILIONERAL HOME 2525 FLEET ST. BALTO. MD. 21224 23. PART I. Enter the diseases, or comp caftons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate interval Betw IMMEDIATE CAUSE (Final Onset and Death traumatic event, the disease or condition resulting in death) REND FALLURE
DUE TO (OF AS A CONSEQUENCE OF): 2 WKS CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): FAILURE or other resulting in death) LAST 83 107 Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY 23 shows any 1 TYES A OF DEATH? 1 | YES 2 | NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hell EXAMINER? THE HOSPITAL OR: ATTENDING PHYSICIAN: The THE FUNERAL DIRECTOR: After this certificate I flied within 72 hours after death with the State HOSPITAL: OTHER: Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) marked, or 27. MANNER OF BEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DEŞCRIBE HOW INJURY OCCURED 5 Pending Investige Natural 1 YES 2 NO BY 2 Accident 3 Suicide 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28 is 8 Could not be determined 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 4 Homicide item ; 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated IMPORTANT: If investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated. 296. SKINGTURE AND TITLY OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE D15135 93 23 2 OON BROADWAY CHURCH HOSPITAL DR P. APR 08 1993 Davidson fonder

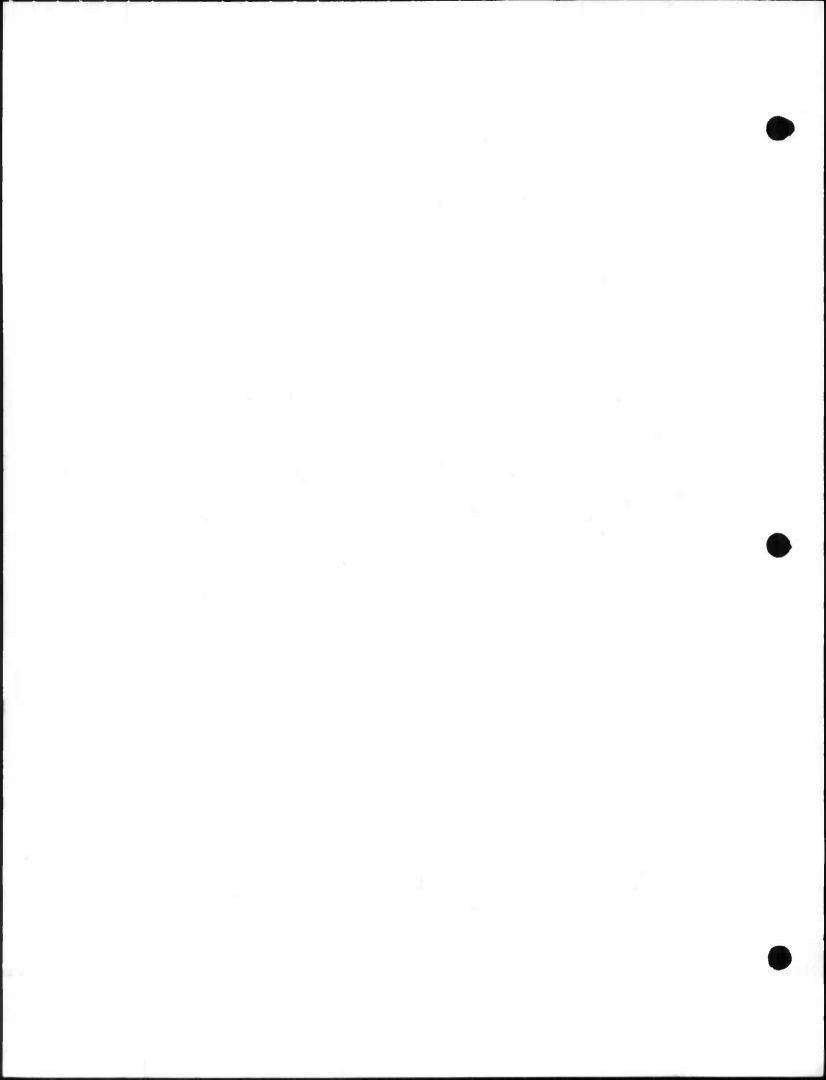
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

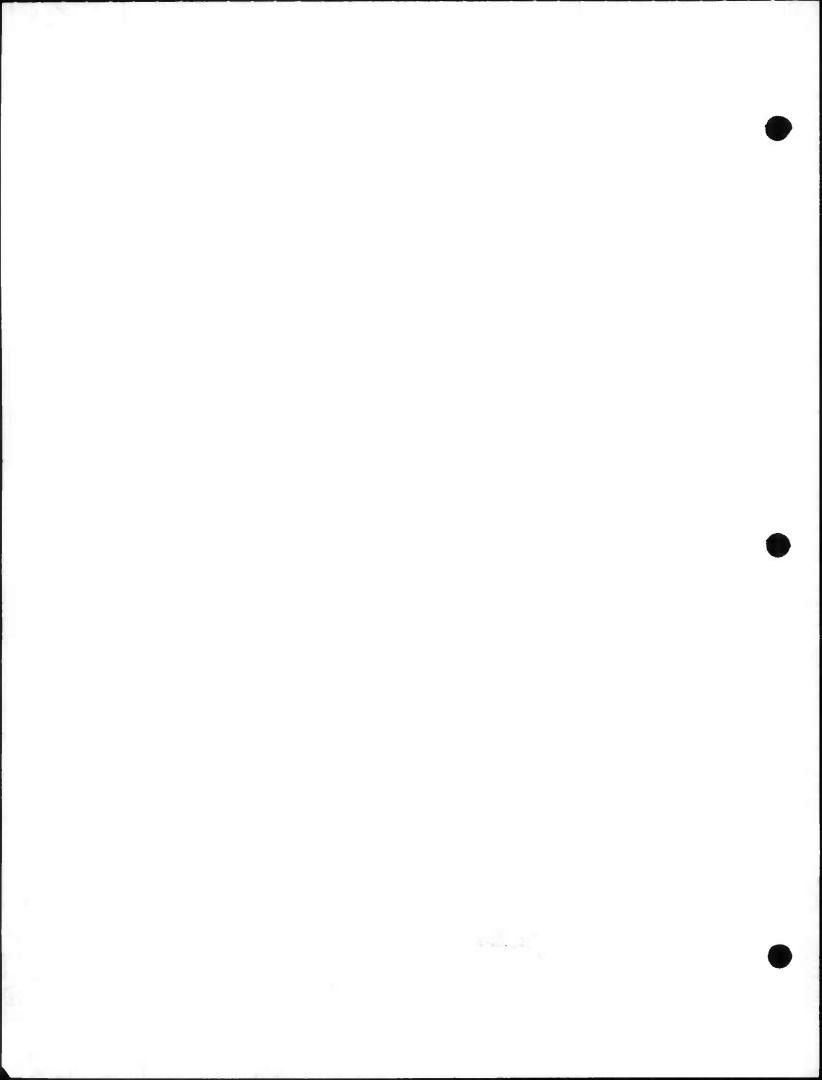
	TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law inquires that the death certificate be oxecuted within 24 fours after death. Plage 6 may be retained by the hospital or attending	TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physicien and completely filled in by the tuneral director, page 5 should be detached for use as the be filled within 72 hours after death, with the State Dest. of Health and Mental Heriens prior to build, committed, or sensoon	
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	Ped	pino	pe
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	ours a	d in by	medic
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	il il	TO THE RUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the tunnar be filled within 22 hours after death with the State Dest, of Health and Merical Heatens price to burial, completely are seminant.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARYLAND	/ DEPARTME	NT OF HEALTH AN	D MENTAL HYG REG.				
Ü	1. DECEDENT'S NAME (First, Middle, Lost) Ernestine		Roge	rs	2. DATE OF DEAT MONTH May.		3. TIME OF DEATH 4:45 A		
	257 24 3420	5. SEX 6. AGE (In yrs. In 1) 6. AGE (In yrs.	est birthday) IF UI YRS. MONT	NDER 1 YEAR IF UNDER 24 HE HB DAYS HOURS MH		r)	BIRTHPLACE (State or Foreign Country) Atlanta, GA.		
TOR	Southern Mar RESIDENCE OF DECEDENT	yland Hospi	tal 9b.	Clinto			v of DEATH		
DIRECTOR	10a. STATE 10b. COUNTY	George		n or Location linton			10d. INSIDE CITY LIMITS? 1 📉 YES 2 🗌 NO		
FUNERAL	10e. STREET AND NUMBER	<del>-</del>		10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?			
NE	9211 Stuart Lane	12. WAS DECEDENT EVER IN U.S. 4		2073			.S.A.		
BY	11. MARITAL STATUS  1 XXNever Married 2 Married  3 Widowed 4 Divorced	NO	13. WAS DECENDENT OF HIS If yes, specify Cuban, Ma 1 YES 2 XNO St	cify Yes or No. 14, RACE — American Indian.					
COMPLETED		mpleted) ( College (1-4 or 5 +)	DECEDENT'S USUAL Give kind of work ok te. Do NOT use retire	one during most of working		D.C. Recreation Dept			
	17. FATHER'S NAME (First, Middle, Last) Unobtainabl		ride		NAME (First, Middle, Me	iden Sumame)	Ton Seper		
H	19a. INFORMANT'S NAME (Type/Print)		9b. MAILING ADDR	ESS (Street and Number or Ru			orie)		
2	Karl M. Rogers/so				itland, Mar				
	20e METHOD OF DISPOSITION 1 M Burlel 2 Cremation 3 Remove Donation 5 Other (Specify)	al from State 20b.PLACE cemetery, co	E AND DATE OF DIS			Landov	y or Town, State		
	21. SIGNAPURE OF PUNERAL BERVICE LICEN	les de		22. NAME AND ADDRESS OF	PADILITY /	100	SE LINDO		
TION	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	Esopha	OUENDE OF):	for the mode of dying,  and  and  and  and  and  and  and  an	tuch as cardiac orn	espiratory arrea	t, Approximate Interval Between Onset and Death		
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	CAUSE (Disease or Injury that initiated events OUE TO (OH AS A CONSEQUENCE OF):							
-	PART II. Other significant conditions of								
MEDIC/		contributing to death but not	resulting in the	underlying cause given	PEF	S AN AUTOPSY FORMED? S 2 NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO		
AN: MEDICA		contributing to death but not	resulting in the		PEF 1 - YE	FORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
SICIAN: MEDICA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	ОТН	26. PLACE OF DEATH IER:	PEF 1  YE	FORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
HYSICIAN: MEDICA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL: Inpetier 2 DEWOutpatien 28s. DATE OF INJURY	3 DOA OTH	26. PLACE OF DEATH	(Check only one)	FORMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2  NO		
BY PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  17. MANNER OF DEATH  1 Natural 5 Pending investigation	IOSPITAL:  Inpetierr 2 ER/Outpatierr  28a. DATE OF INJURY (Mooth, Day, Wee)  28a. PLACE OF BUURY — At b.	3 DOA OTH	26. PLACE OF DEATH IER: furning Home 5   Residen 28d. INJURY AT WORKY 1   YES 2   NO	(Check only one)  8 Other (Specify)  28d. DESCRIBE HO	FORMED?  S 2 NO  NO  NO  NO  NO  NO  NO  NO  NO  NO	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2  NO		
	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  1 NANNER OF DEATH  1 Natural 5 Pending Investigation 2 Accident Investigation 3 Subtride 6 Could not be determined	IOSPITAL:  Inputient 2 ER/Outpatient  28a. DATE OF INJURY (Month. Day, Year)  28a. PLACE OF INJURY — At In- building, etc. (Specify)	25b. TIME OF INJURY M	26. PLACE OF DEATH IEER: ***********************************	(Check only one)  8  Other (Specify)  28d. DESCRIBE HO  281. LOCATION (Str. City or Town, S	FORMED?  S 2 NO  W INJURY OCCUP  Beet and Number or  Gete)	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2 NO  RED		
COMPLETED	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	IOSPITAL:  Inpetierr 2 ER/Outpatierr  28a. DATE OF INJURY (Mooth, Day, Wee)  28a. PLACE OF BUURY — At b.	3 DOA OTH 25b. TIME OF INJURY M ome, farm, street,	26. PLACE OF DEATH IETE: ***Burning Home 5	(Check only one)  8 Other (Specify)  28d. DESCRIBE HO  281. LOCATION (Str. City or Town, S	FORMED?  S 2 NO  W INJURY OCCUR  was and Number or reite  manner ee stated.	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2 NO  RED  Rural Route Number,		
BE COMPLETED	25. WAS CABE REFERRED TO MEDICAL  EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Matural 5 Pending Investigation  3 Societe 6 Could not be determined  29e. CERTIFIER (Check only One)  20 MEDICAL EXAMINER:	Inpetiers 2 EN/Outpatient  28a. DATE OF INJURY (Month. Day, Weer)  29a. PLACE OF INJURY — At Information, etc. (Specify)  IN: To the best of my knowledge, d On the basis of examination and/or	29b. TIME OF INJUSTY  29b. TIME OF INJUSTY  and the street, street, in many the street	26. PLACE OF DEATH IER: ************************************	(Check only one)  8 Other (Specify)  28d. DESCRIBE HO  281. LOCATION (Str. City or Town, S	FORMED?  S 2 NO  W INJURY OCCUR  weet and Number or reite)  manner ee stated.	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2  NO  RED  Rural Route Number,		
TO BE COMPLETED	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	Inpetiers 2 EN/Outpatient  28a. DATE OF INJURY (Month. Day, Weer)  29a. PLACE OF INJURY — At Information, etc. (Specify)  IN: To the best of my knowledge, d On the basis of examination and/or	29b. TIME OF INJUSTY  29b. TIME OF INJUSTY  and the street, street, in many the street	26. PLACE OF DEATH IETE: ***Burning Home 5	(Check only one)  8 Other (Specify)  28d. DESCRIBE HO  281. LOCATION (Str. City or Town, Str. City or Town,	FORMED?  S 2 NO  W INJURY OCCUR  weet and Number or reite)  manner ee stated.	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2 NO  RED  Rural Route Number,		



STATE O	F MARYLAND /	DEPARTMENT	OF HEALTH	AND	MENTAL	HYGIENE
	CI	ERTIFICATE	OF DEAT	H		REG. NO.

	FOR STATE REGISTRAR	STATE OF MAR	RYLAN	D / DEPAR CERTIF	TMEN	OF H	EALTH A	ND MENT	TAL HYGIEN			0 0 0 0 0 0 0
	1. DECEDENT'S NAME (First, Middle, Last)							2. D/	TE OF DEATH		100000	3. TIME OF DEATH
	ASBURY	J.		RUDE	,Sr	•		40	мтн в 5		YEAR 1993	7:55 A M
	4. SOCIAL SECURITY NUMBER 241 - 24 - 4336	5. SEX 6. / 1 💢 M 2 🗌 F	6 9	s. last birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER 24 I		TE OF BIRTH	923	8. BIRTH Countr	PLACE (State or Foreign
	9e. FACILITY NAME (If not institution, give st 1117 RUTLAND						IMORE		v	9c. COU	NTY OF D	EATH
2	RESIDENCE OF DECEDENT	AVENUE			Ь	ATIT	INORE	, СТТ				
DIRECTOR	10e. STATE 10b. COUNTY	,		Bal:	timo		ION	_				10d. INSIDE CITY LIMITS?  1XX YES 2 NO
AP	10e. STREET AND NUMBER					101	. ZIP COOE					HAT COUNTRY?
FUNERAL	1117 Rutland				_		2121				S A	
BY PU	1 Never Married 2 Merried 3 Wildowed 4 Divorced	Merried FORCEST 1 YES 2/ MO II yes, specify Cuben, Mexican, Puerto Rican, etc.)  Bleck, Wh						- American Indian, White, atc.  Black				
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	164	(Give kind of v	vork done	CCUPATIO	ON st of working		166. KIND OF BU	SINESS/INI	DUSTRY	
M												
S S	17. FATHER'S NAME (First, Middle, Last) Asbury Rudd								te Ric		dson	
0	19a. INFORMANT'S NAME (Type/Print)					(Street a			umber, City or Tow			-
-	Asbury Rudd, J	r		82	L E.	41	st St	reet				21218
	20e. METHOD OF DISPOSITION 1 Burlel 2/ Cremation 3 Remo 4 Donation 5 Other (Specily)		cometer	CEAND DATE OF	ret	ato	ry	14)			City or To	
Ì	21. SIGNATURE OF TUNERAL SERVICE LIC	ENSEE			22. N	NAME AN	h F/F	OF FACILITY	+			
	- Wisana	rounds	$\mathcal{L}_{-}$	<u> </u>	_   4	300	Waba	ash	Avenue	,		
	23. PART i. Enter the diseases, or c shock, pr heart failure. I iMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one cause of the caus	on aach	lina.								Approximate Interval Between Onset and Desth
CENTICATION	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST			NSEQUENCE OF								
۱	PART ii. Other significant conditions	s contributing to dea	th but n	ot resulting i	n tha un	deriying	cause give	n in Part i.	PERFOR	MED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE
: MEDIC									parts	al		DF DEATH?  1 XYES 2 NO
SICIAN.	25. WAS CASE REFERRED TO MEDICAL					26. PL	ACE OF DEAT	H (Check only	one)			
وَ ا	EXAMINER?  1 X YES 2 NO	HOSPITAL: 1   Inpatient 2   ER/	Outpatier	nt 3 □ DOA	OTHER 4 Nun	t: sing Hom	5 Reelde	ince 8 🗆 O	ther (Specify)			
	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28e. OATE OF INJU (Month, Day, Ye	JRY ear)	28b. TIMI	E OF URY M	28c. INJ WO 1   \			ESCRIBE HOW I	NJURY OC	CURED	
150 0	3 Suicide 8 Could not be determined	28e. PLACE OF INJ building, stc.	IURY — A (Specify)	M home, farm, s	treet, fact	ory, office		28f. L	OCATION (Street of ity or Town, State)	and Number	or Rural R	oute Number,
OMPLE	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC 2 MEDICAL EXAMINER											and menner ee stated.
2	296. SIGNATURE AND TITLE OF CERTIFIER		(kh				29c. LICENSE	-				(Month, Day, Year) 1993
	30. NAME AND ADDRESS OF PERSON WHE	COMPLETED CAUSE OF	F OEATH	(ITEM 27) (Type, 1 Pen)	Print) n St	ree	et, Ba	altim	ore, N	Mary	land	21201
I	APR 08 1993	STATE STEAM	Herriff	adeble.								



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 frours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR 1 - STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	REGISTRAR		CERTIFI	CATE OF	DEATH	F	REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Lest) Baby Boy Randall	BABY Bo	Y RAN	DALL	A'TWIN	2, DATE OF MONTH	26	6-93 93	3. TIME OF DEATH 4.30 PM
		1 🔀 M 2 🗆 F	YRS.	F UNDER 1 YEAR	HOURS MIN.		BIRTH ny. Ybar) 2693	Count	HPLACE (State or Foreign rv) Maryland
TOR	9a. FACILITY NAME (If not institution, give street BM C RESIDENCE OF DECEDENT	et and number)		9b. CITY, TOWN	CTIMO	RE		BAL	MORE
DIRECTOR	10a. STATE 10b. COUNTY			TOWN OR LOCA ltimore					10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	10e. STREET AND NUMBER 5101	Walter Avenu	е	10	f. ZIP CODE	21214	10g.		WHAT COUNTRY?
В	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	U.S. ARMED 2 NO ES	If yes, sp	CENDENT OF HISPAI ecify Cuban, Maxics 2 NO Specif	n, Puerto Rice		E — American Indian, k, White, etc.		
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade co Elementary/Secondary (0-12)	COllege (1-4 or 5+)	16a. DECEDENT'S U (Give kind of wo life. Do NOT use	rk done during me	ON sst of working	16b. Kif	ID OF BUSINESS	INDUSTRY	
BE COM	17. FATHER'S NAME (First, Middle, Last) De	rrick Bradle	À		16. MOTHER'S NA		e, Maiden Surnam Renita	-,	111
	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	DDRESS (Street a	and Number or Rural	Route Number, (	City or Town, State,	Zip Code)	
TO	Renita Randall  20e. METHOD OF DISPOSITION 1 Burlel 2 Cremetlon 3 Remove		5101 W	DISPOSITION (NO	venue.Ba	lto.MD	21214 20c. LOCATION	— City or Te	own, Stata
	4 Donation 5 Other (Specify)	-/-							
	SUMMERAL SERVICE LICEN	Romald W	ade, Dir 4/6/93		.Baltimo	St	ate Ana alto,MD		
	23. PART I. Enter the diseases, or con shock, or heart failure. Lie	mplications that caused	the death. Do no	t anter the mo	da of dying, auc	h aa cardlec	or reapiratory	arrest,	Approximata
	imiEDIATE CAUSE (Final sease or condition resulting in deeth)	CAR	DIO PL	LMON	ARY,	ARRI	EST		interval Between Onset and Death
NO	Sequentially list conditions,  DUE TO (OR AS A CONSEQUENCE OF):  EXTREME IMMATURITY  DUE TO (OR AS A CONSEQUENCE OF):								
CAT	If any, leading to immediate cause. Enter UNDERLYING		,						
CERTIFICATION	cause (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A C	CONSEQUENCE OF)						
	PART II. Other algnificant conditions	contributing to deeth but	not reaulting in	the undarlyin	g cause given in	Part I. 24	. WAS AN AUTOP:	SY 246	. WERE AUTOPSY FINDINGS
MEDICAL							PERFORMED?		AMAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH?  1 YES 2 NO
A N									
PHYSICIAN:		HOSPITAL:		OTHER:	ACE OF DEATH (Ch				
¥	1 YES 2 NO 1	28a. DATE OF INJURY	28b. TIME		e 5 Residence			OCCUPED	
	1 Natural 5 Pending	(Month, Day, Year)	INJU	RY WC	PRK?	260. DESCHI	BE HOW INJURY	OCCOMED	
TED BY	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. PLACE OF INJURY — building, etc. (Specify	- At home, farm, str	eet, factory, offic	•		N (Street and Num wn, State)	ber or Rural i	Route Number,
COMPLETE		AN: To the best of my knowled On the basis of examination of							i) and manner as stated.
BE	SW. SIGNATURE WILL OF CERTIFIER	MBADAS F	ATHAK	(C.M.)	29c. LICENSE NUM			ATE SIGNED	(Month, Day, Year)
2	ATBADAS PAT	COMPLETED CAUSE OF DEAT	H (ITEM 27) (Type, F	rine)					
	APR - 8 1993	32. REGISTRAR'S SIGNAT	URE					_	



BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	
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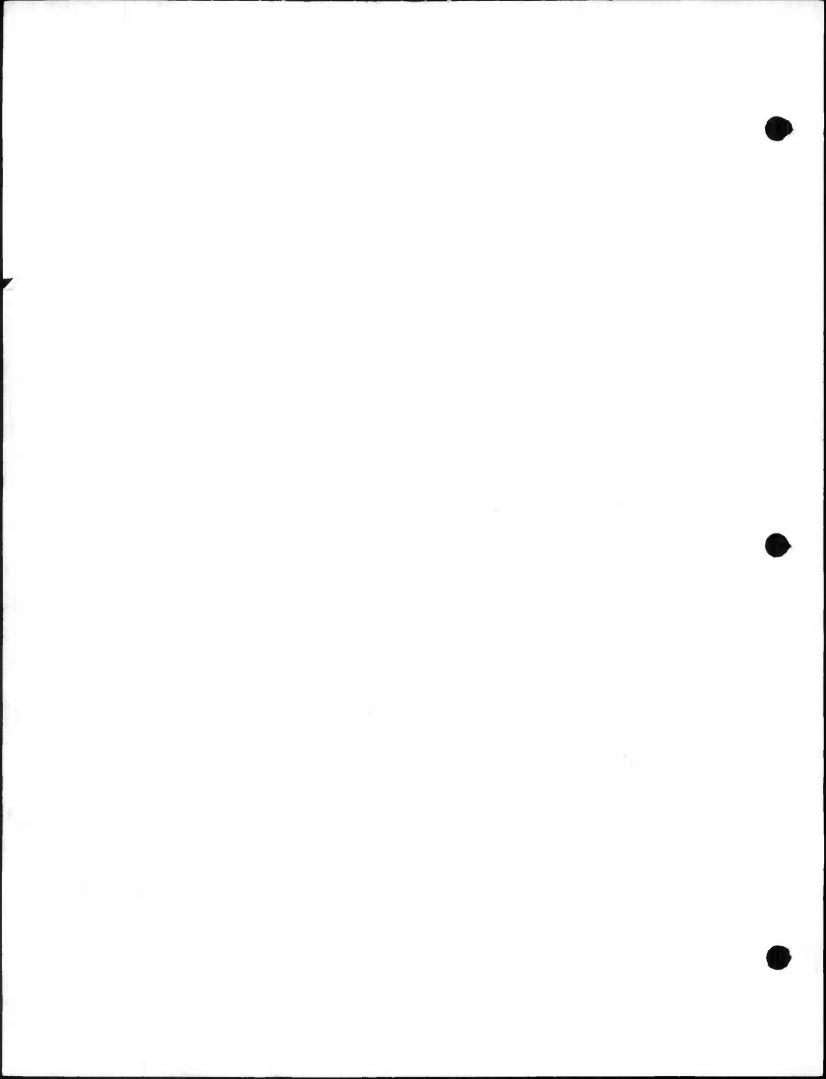
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR KENNARD ROBERTS JR. 4 1993 03 4. SOCIAL SECURITY NUMBER 7. DATE OF BIFITH (Month, Day, Year 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) DAYS HOURS 213-86-0810 12 M 2 | F 2-29-1968 26 BALTIMORE, MD. for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 96, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR **bALTIMOKE** SETON HILL NURSING HOME **BALTIMORE** RESIDENCE OF DECEDENT 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD. BALTIMORE CITY 1 YES 2 | NO FUNERAL 10e. STREET AND NUMBER 101 ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? USA. 24 hours after death. Page 6 may be retained by the hospital or attending physician. filled in by the funeral director, page 5 should be detached for use as the buriat-tran 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1X Never Married 2 Married BY Specify: 3 Widowed 4 Divorced BLACK COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) UNEMPLOYED once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) BE KENNARD ROBERTS THERESA L. SMITH notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 HORN 1711 LORMAN STREET, BALTIMORE, MD. 21217 pe 20a. METHOD OF DISPOSITION

1 2 Burlai 2 Cremation 3 Removal from Stale
4 Donation 4 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must 4 Donation 5 Other (Specify) METRA (RFMATORY BALTIMORE, MD. the medical examiner 22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTINDRE ST. BALTO. MD. 21223; P.O. BOX 4433 attending physician and completely filled in by the cremation, or removal. 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Final disesse or condition Acto innune Defeciency Syndrone
DUE TO (OR AS A CONSEQUENCE OF): event, resulting in death) prior to burial, In Rech! traumatic CERTIFICATION Sequentially list conditions, if sny, leading to immediate DUE TO (OR AS A CONSEQUENCE OF) cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 Menta signed by the a Health and Men PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO shows any COMPLETION OF CAUSE 1 TYES 2 T NO 1 TYES 2 T NO certificate has been h the State Dept. of PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? ent 2 🗆 ER/Outpatient 3 🗀 DOA sing Home 5 ☐ Residence 8 ☐ Other (Specify) 6 27. MANNER OF DEATH 28a, DATE OF INJURY 28b. TIME OF this c. 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED marked, Netural 5 Pending 1 YES 2 NO BY After death Accident 28a. PLACE OF INJURY — Al home, farm, street, fectory, offica building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 69 8 Could not be determined COMPLETED DIRECTOR: I 28 4 Homicide Item Tem CERTIFIER
(Check only one)

A Targetti String Physician: To the best of my knowledge, death occurred at the time, data and place, and dus to the cause(a) and manner as stated. 29s. CERTIFIER FUNERAL I = 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. TO THE HOSPITA
TO THE FUNERA
DE filed within 7. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 4.6.93 D43786 leer 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 54 Laberte He Beltinore 21216 32 REGISTRAR'S SIGNATURE

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

134 85 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCIENE

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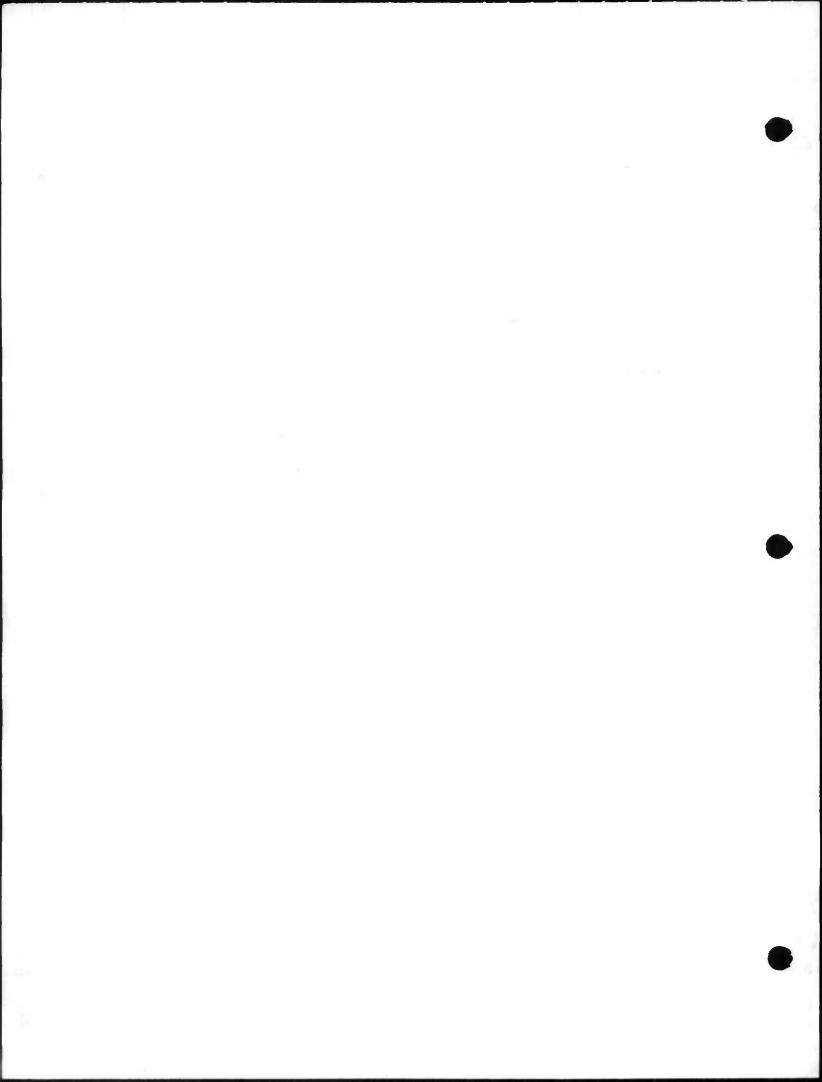
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	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAI CERTIF	RTMENT OF I	EALTH AND DEATH	MENTAL HYGIE			
	1. DECEDENT'S NAME (First, Middle, Last)	Robert	John	Riffe		2. DATE OF DEATH MONTH	YEAR	3. TIME OF DEATH	
	218-36-7981	1 № 2 □ F 5	In yrs. last birthday)  3 YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 10-21-19	39 Det	ATHPLACE (State or Foreign unity) Troit, Mich.	
TOR	96. FACILITY NAME (If not institution, give street end number)  96. CITY, TOWN OR LOCATION OF DEATH  96. COUNTY OF DEATH  96. COUNTY OF DEATH  96. COUNTY OF DEATH  96. COUNTY OF DEATH  96. COUNTY OF DEATH								
DIRECTOR	10. STATE 10b. COUNTY Maryland	Baltimore	10c. CIT	Y, TOWN DR LOCA	Dunc	dalk	ek 10d. INST		
FUNERAL	100. STREET AND NUMBER  34 North Dundalk	Avenue Ap	t #1	10	. ZIP CODE	1222		ted States	
BY		12. WAS DECEDENT EVER IN FORCES? 15 YES, GIVE WAR OR DI ATUMU KOTE	U.S. ARMED 2 ND	If yes, ap		NIC ORIGIN? (Specify Year, Puerto Ricen, etc.)	В	ACE — American Indian, ack, White, etc.	
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade co	TION	16e. DECEDENT'S (Give kind of life. Do NOT u	USUAL OCCUPATI work done during me se retired.)	ON st of working	16b. KIND OF BI	USINESS/INDUSTRY	,	
OM	17. FATHER'S NAME (First, Middle, Last)		Macra	enunce	16. MOTHER'S NA	AME (First, Middle, Meide	n Surneme)		
BEC	Paul Riffe				Mabel B		,		
TO B	190. SHORMANT'S NAME (Type/Print) ANNE Marie Riffe					Poute Number, City or To			
	20e. METHOD OF DISPOSITION 1	al from State 20b	PLACE AND DATE	OF DISPOSITION (N	ame of	DATE 20c. L	OCATION — City or	Town, State	
	21. SIGNATULE OF PULBRAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  Duda-Ruck Funeral Home of Dundalk, Inc.  7922 Wise Ave. Dundalk, Maryland 21222								
	29. PART I. Enter the diseases, or cor	mplications that caused	the deeth. Do	not anter the mo	de of dying, auc	h aa cardiec or ree	piratory arreat,	Approximate	
	shock, or heart failure. Lie iMMEDIATE CAUSE (Fine) disease or condition resulting in death) e.	MET A		CA.	LUN	16		interval Between Onset and Death	
CERTIFICATION	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury c								
ERTIF	that initieted events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE O	F):					
PHYSICIAN: MEDICAL C	PART II. Other aigniticent conditions	contributing to deeth b	ut not resulting	in the underlyin	g cause given in	Part I. 24a. WAS A PERFO	RMED?	4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 ND	
Y Y	25. WAS CASE REFERRED TO MEDICAL			28. Pi	ACE DF DEATH (Ch	eck only one)			
28		IOSPITAL:	etlent 3 DOA	OTHER:		6 Other (Specify)			
	27. MANNER OF OEATH  1 Natural 5 Pending	28a. OATE DF tNJURY (Month, Day, Year)	28b. TIM	E OF 28c. INJ		28d. DESCRIBE HOW	INJURY OCCURED	<del></del>	
TED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	getion  28e. PLACE OF INJURY — At home, farm, street, tactory, office building, atc. (Specify)  28f. LOCATION (Street and Number or Rural Ro							
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA 2 MEDICAL EXAMINER:							e(e) end menner se stated.	
BE C	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI		29d. DATE SIGN	EO (Month, Day, Year)	
면 인	A-K. Na	Beny.	~~	>	D17	322	1 4/	6/93	
-	30. NAME AND ADDRESS OF PERSON WHO			Print)					
	APR 08 1993	32. BEGISTRAR'S SICH	TURE						



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3. TIME OF DEATH

REG. NO

2. DATE OF DEATH

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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0.5 04 1993 ROCCHI 7:15PM M JOHN4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs, lest birthday) 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR | IF IMDER 24 HRS 1/ M 2 | F DAYS HOURS 213-07-5566 96 YRS 06/21/1896 Italy Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH G.B.M.C.,6701 N.CHARLES STREET DIRECTOR TOWSON BALTIMORE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE TIMONIUM 1 - YES 2 - NO permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1900 POT SPRING ROAD use as the burial-transit 21093 U.S.A. hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indien, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 1 Never Merried 2 Married If yes, specify Cuban, Mexican, Puerto Rican, atc.)

1 YES 2 NO Specify: IF YES, GIVE WAR OR DATES BY Specify: 3 Widowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest gi Por Elementary/Secondary (0-12) College (1-4 or 5+) Contractor Self-Employed 12 yrs. Rocchi Construction Co, funeral director, page 5 should be detached once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Nazareno 70 Rocchi Theresa Neri BE notified 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Tonina Rocchi Same as #10 g 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Stata OATE must Dulaney Valley Mausoleum 4/8/93 Timonium, Maryland 21. SIGNATURE OF FEWERAL SERVICE DICENSES examiner 22. NAME AND ADDRESS OF FACILITY 1050 York Rd a Ruck Towson Funeral Home, Inc. Towson, Md. has been signed by the attending physician and completely filled in by the bept. of Health and Mental Hygiene prior to burial, cremation, or removal. medical 23. PART I. Enter the diseases, or confplications the coursed the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. Ust only one apply on each line. Approximate Interval Between **IMMEDIATE CAUSE (Final** Onset and Death the disesse or condition executed within 24 respilation event. resulting in death) TO (OR AS A CONSEQUENCE OF) reumana traumatic CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): if any, landing to immediata cause. Enter UNDERLYING death certificate be CUA CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. law requires that the MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AMAILABLE PRIOR TO any COMPLETION OF CAUSE 1 WES 2 PNO Shows 1 TES 2 NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) certificate h tem **EXAMINER?** HOSPITAL OTHER: 1 YES 2 NO ATTENDING PHYSICIAN. 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 6 27. MANNER OF DEATH 28a. OATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c, INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED After this co marked, 1 Natural 1 YES 2 NO BY 2 Accident 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28e. PLACE OF INJURY - At home, term, street, fectory, office 3 Suicide HOSPITAL OR ATTUTORS A FUNERAL DIRECTORS A WITHIN 72 hours after d - 66 Could not be COMPLETED 4 Homicide 28 Hem 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) end manner as stated. FUNERAL ( = 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: 8 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Morgth, Day, Year) BE 60 Sect うかり 1)30910 41 5/93 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stolt York Rd. 32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be excuted within 22 fours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiere prior to burial, cremation, or removal.

IMPORTANT: If Hem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

1 - FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

	***************************************				10/1/2	· DEA		NEG. NO			
	1. DECEDENT'S NAME (First, Middle, Last) Rev. James S. Scott  2. DATE OF DEATH MONTH DAY OF 93							YEAR 9:25 P			
1 3	4. SOCIAL SECURITY NUMBER	1	8. AGE (In yrs. las					7. DATE OF BIRTH			
	213-09-2256					8 HOURS	MIN.	(Month, Day, Year)		6. BIRTHPLACE (State or Foreign Country) Georgia	
l	9e. FACILITY NAME (If not institution, give		1		96. CITY, TOV			ГН	9c. COUN	ITY OF DEATH	
DIRECTOR	Bon Secours	Hozbila	-		591	timo	re				
	10e. STATE 10b. COUN	TY		10c, CIT	Y, TOWN OR LO	CATION				10d. INSIDE CITY	_
	Md.				Balt:					LIMITS?	
FUNERAL	3306 Fairview	Avenue				101. ZIP COD 21	216		10g. CITIZ	USA.	1
=	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. AR	MED	13 WAS	DECENDENT (	OF HISDANIC	ORIGIN? (Specify Yes	or No.	14 BACE American Indian	_
	1 Never Merried 2 Merried		YES 2X	ID	If yes	specify Cube	nn, Mexican,	Puerto Rican, etc.)		14. RACE — American Indian, Black, White, atc.	
B	3 Widowed 4 Divorced	IF YES, GIVE WA	A OR DATES		10	ES ENO	Specify:			Specify: Black	
8	15. DECEDENT'S ED	UCATION	16a. DE	CEDENT'S	USUAL OCCUP	ATION		16b. KIND OF BUS			-
<b>5</b>	(Specify only highest gra-	College (1-4 or 5+)	(Gi	Do NOT u	work done during se retired.)	most of workli	ng				
릴				nis	ter			Reli	gior	1	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			-		18. MOT	HER'S NAME	(First, Middle, Malden	Surname)		
ш	Andrew Sco	tt				Ca	roli	ne Bac	key		
00	19e. INFORMANT'S NAME (Type/Print)		198	. MAILIND	ADDRESS (Stre	et and Number	r or Rural Rou	ute Number, City or Tow	n, State, Zip	Code)	
임	Polly M. Sco	tt		330	6 Fair	rview	Ave	. Balto.	, Mc	1. 21216	
	201/METHOD OF DISPOSITION 1 & Burlel 2 Cremetton 3 Re	moval from State			of disposition	(Name of		4/12 Lau	CATION —	City or Town, State	
	4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE I	ICENSEE	Ma.	Nac		AND ADDRE				, Più.	
1 1			James A. Morton & Sons								
	· James	1100 sc	en	1701 Laurens St. Balto., Md.21					., Md.21217		
	23. PART Enter the diseases, or ahock, or heart failure	complications that	caused the de	ath. Do i	not enter tha	mode of dy	ing, auch	aa cardiec or respi	retory arm		
	IMMEDIATE CAUSE (Final	on cade	on each line		1					Onset and Deat	
	disease or condition resulting in deeth)	. 100g	mal	nu	fait	ny					
	DUE TO (OR AS A CONSEDUENCE OF):										
CERTIFICATION	Sequentially list conditions,  Due to sol as a consequence on:								_		
TA.	If any, leading to immediate cause. Enter UNDERLYING										
Ĕ	CAUSE (Disease or Injury that Initiated eventa DUE TO (OR AS A CONSEQUENCE OF):										
F	resulting in death) LAST	d. H/	18CV	10							
1 11	PART II Other elevational conditions contributing to death but not required in the condition in the conditions of the conditions in the condition in the condit										
EDICAL	DEDECOMED?							24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO	S		
ğ	SIR Asdounted Su				240 1 2 4 .					OF DEATH?	
2	- 0/1 /19	1 VES					1 TYES 2 NO				
AN											
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER:	PLACE OF D	EATH (Check	conty one)			-
l ≼	1 YES 2 AND 27. MANNER OF DEATH	1 5 Impatient 2 🗆						Other (Specify)			
РНУ	1 Natural 5 Pending	28e. DATE OF I (Month, Day	r, Year)	28b. TIM	IURY	INJURY AT WORK?		ed. DESCRIBE HOW I	NJURY OCC	URED	
BY	2 Accident Investigation		AN HARV AN hou			YES 2					4
9	3 Suicide Could not be determined	building, a	INJURY — At ho tc. (Specify)	me, Iarm,	street, factory, c	ffice	2	Bi. LOCATION (Street a City or Town, State)	and Number	or Rural Route Number,	
I III I	290. CERTIFIER 1 CERTIFYIND PHY	OLOVANI. To the board							-		-
COMPL		SICIAN: To the best of m NER: On the basis of exa								ed. e ceuse(e) and manner ee stated.	
	29b. SIGNATURE AND TITLE OF CERTIFI		,				ENSE NUMBI			SIGNED (Month, Day, Year)	4
BE	My Tou	all				102	625	6	D 4	1/7/92	
유	30. NAME AND ADDRESS OF PERSON W	HD COMPLETED CAUSE	E OF DEATH (ITE	1 27) (Type	, Print),			1 1		1110	$\dashv$
	BICH DUONE	700	Wast	449	ston	BI	Vol	Balto	MI	21230	
APR 08 1993 32. BRIST RATE SIGNATURE APRIL 1993											

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

and the shall be a second

DIVISION OF VITAL RECORDS, P.O. BOX 68/60, BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
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	1 - STATE REGISTRAR	STATE OF MARY		RTMENT OF H		MENTAL HYGIEN REG. NO.		
	1. DECEDENT'S NAME (First, Middle,	Rodward M				2. DATE OF DEATH DO	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER	7/	(In yrs. last birthday)	# UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)	
	9a. FACILITY NAME (If not institution.		4 YRS.		OR LOCATION OF DE	Mar. 13,1	.919 Maryland	
8	Mercy Hospita			1	altimore		SC. COUNTY OF DEATH	
1 5	RESIDENCE OF DECEDEN	Ť	the CD	TY, TOWN OR LOCAT	TION!			
DIRECTOR	Maryland Harford			Forest H			10d. INSIDE CITY LIMITS?  1 YES 2 XXNO	
	10e. STREET AND NUMBER				I. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?	
NE R		Drive, Apt. N			21050		U.S.A.	
BY FUNERAL	11. MARITAL STATUS  1 Never Married 2 Married  3 Wildowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 X YES IF YES, GIVE WAR OR	2 NO	If yes, sp		IIC ORIGIN? (Specify Yes n, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc. Specify: White	
COMPLETED	15. DECEDENT'S (Specify only highest		(Give kind of	USUAL OCCUPATION	ON ist of working	16b. KIND OF BUS	SINESS/INDUSTRY	
P.E.	Elementary/Secondary (0-12)	College (1-4 or 5+) N/A	Brick	:layer		Union	Local # 1	
	17. FATHER'S NAME (First, Middle, Las		DITCK	layer	18. MOTHER'S NA	ME (First, Middle, Maiden		
BEC	Robert	Szech			Lida	Mallo	n	
P	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Town		
	Josephine M. S	20	b. PLACE AND DATE				cest Hill, MD 21050	
	1 Buriel 2 Cremation 3 4 Donation 5 XOther (Specify)	Entombment   Continue	metary, crematory or d	other place)			timore, Maryland	
	21. SIGNATURE OF FUNERAL SERVICE	E LICENIUS		22. NAME A	ND ADDRESS OF FA	eral Homes		
	Willer			9705	Belair R	oad, Balti	more, MD 21236	
CERTIFICATION	23. PART i. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart feliure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):							
	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  PERFORMED?  AMALABLE PRIOR TO COMPLETION OF CAUSE OF READING.							
N: MEDICAL	1   YES 2   NO COMPLETION OF CAUSE OF DEATH?  1   YES 2   NO							
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PL	ACE OF DEATH (Che	eck only one)		
HYS	1 VES 2 NO 27. MANNER OF DEATH	1 Sepatient 2 ☐ ER/Ou 26a. DATE OF INJURY	28b. TIR	AE OF 28c, INJ	URY AT	6 Other (Specify) 28d. DESCRIBE HOW II	NJURY OCCURED	
ВУ Р	Natural 5 Pending	(Month, Day, Year)	IN.		PRK? YES 2 NO			
COMPLETED	3 Suicide 6 Could no 4 Homicide determine		Y — At home, farm, ecity)	street, factory, offic		28t. LOCATION (Street a City or Town, State)	and Number or Rural Route Number,	
PLE	anal .	PHYSICIAN: To the best of my kno						
8	2   MEDICAL EXA		on and/or investigati	on, in my opinion, d	eath occured at the	time, data and place, an	d due to the cause(a) and manner as stated.	
TO BE	296. SIGNATURE AND TITLE OF CERT	N WHO COMPLETED CAUSE OF D	On My EATH (ITEM 27) (Type	Mains)	29c. LICENSE NUM	7930	29d. DATE SIGNED (Month Day, Year)	
	31. DATE FILED (Month, Day, Year)	J. FELD A2. REGISTBAR'S SIG	MAN,	MO	130	e timor	ie, mo. 21202	
	APR 08 1993	grina Davidson	-pandalle					

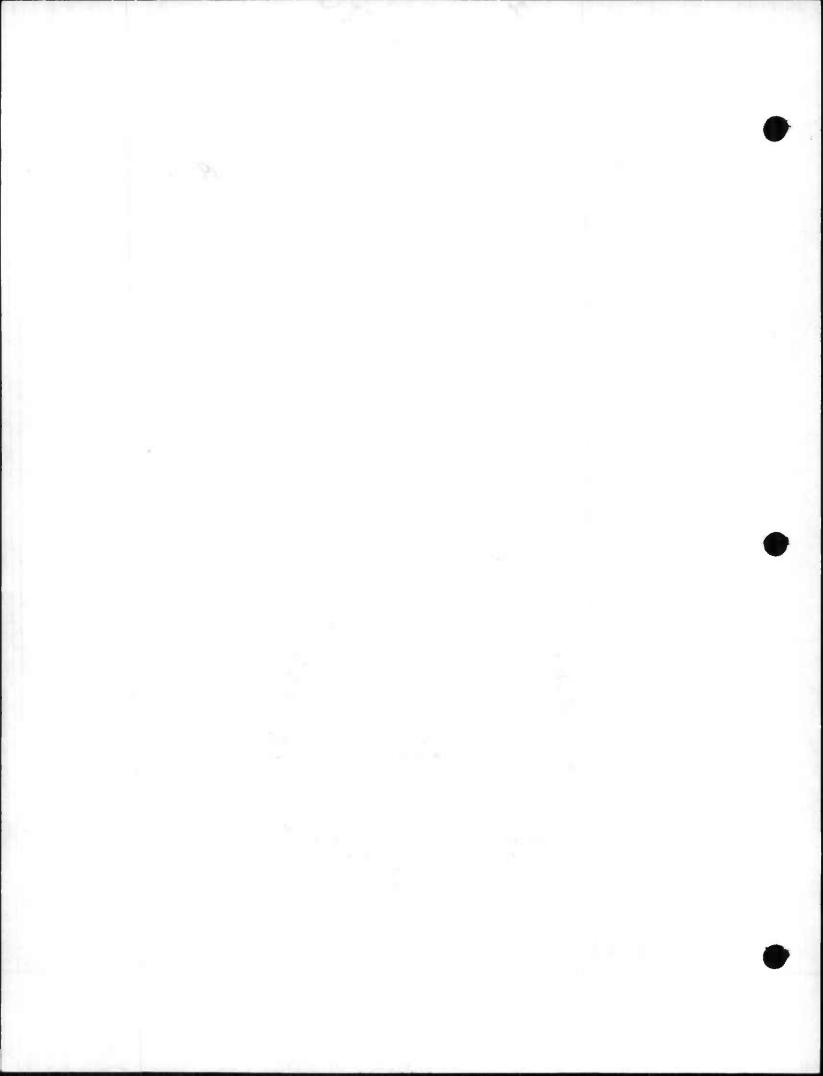
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH Mary Lee Scott MONTH 04 06 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH 38 IF UNDER t YEAR IF UNDER 24 HRS. 6. BIRTNPLACE (State or Foreign DAYE Virginia 1 D M 2 日 F 54 YRS. 216-34-7800 detached for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATN DIRECTOR Baltimore City <u>3710 Park Heights Avenue</u> RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD. Baltimore City 1 TYES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 3710 Park Heights Avenue 21215 U.S. by the funeral director, page 5 may be retained by the hospital or attending physician, in by the funeral director, page 5 should be detached for use as the burlal-tran 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 TO NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 1 1 Married If yes, specify Cuben, Maxican, Puerto Rican, etc.) BY 1 TES 2/ENO Specify: Specify: Black 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. OECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 10th Housewife once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) F Alma Jennings BE notified ; 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Eugene Scott 3710 Park Heights Ave. Balto., MD. 21215 pe 20s. METHOD OF DISPOSITION

1 Dispurse 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State must King Memorial Park 4/10/93 Balto., MD. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE E.L. Phillips F/H 1721-27 N.Monroe ST #281 Balto., MD. 21217 attending physician and completely filled in by the intra Hygiene prior to burfal, cremation, or removal. the medical 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, Approximate shock, or haert failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Finel Onset and Death disesse or condition Cardio vasular Distor Hyperten fene within event, 1 resulting in death) DUE TO (OR AS A CONSEDUENCE OF) executed Mental Hygiene prior to burial, traumatic CERTIFICATION Sequentially list conditions, if any, laading to immediate DUE TO (OF death certificate be cause. Enter UNDERLYING CAUSE (Disease or Injury or other that initiated events resulting in death) LAST Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. this certificate has been signed by the with the State Dept. of Health and Me law requires that the MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? shows any 1 YES 2 NO 1 YES 2 NO PHYSICIAN: Item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) DR ATTENDING PHYSICIAN: The HOSPITAL OTHER: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 - Nursing Ho me 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d, DESCRIBE NOW INJURY OCCURED is marked, death with 1 Natural 5 Pending Investigation BY 1 YES 2 NO FUNERAL DIRECTOR: After within 72 hours after death 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 28 4 Homicide Hem 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) end menner as stated. HOSPITAL TO THE FUNERAL C be filed within 72 h IMPORTANT: If it 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 29d. DATE SIGNED (Month, Day, Year) BE 불분물 -97 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 32. REGISTRAR'S SIGNATURE

- 1	1. DECEDENT'S NAME (First, Middle, Last	CORA ELI	[ZABETH	RIMENT OF ICATE OI SPATH		2. DATE O	F DEATH 4-7-93	3. TIME OF DEA		
	Cora	Spath		DIAIII		монтн 4	DON / J	93 5:50		
	4. SOCIAL SECURITY NUMBER 215-34-7338	1 - M 2 DF	(In yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	7	19-06	Bluefield, b		
0 B	St. Joseph Hosp			10	OR LOCATION OF D	DEATH		trofoeath Ltimore Cou		
DIRECTOR	10a. STATE 10b. COUN	na na	10c. CIT	ry, TOWN OR LOC Balt	imore			10d. INSIDE CIT LIMITS? 1 YES 2		
FUNERAL	100. STREET AND NUMBER 4010 Bateman Av	venue		1	IOF. ZIP CODE	16		EN DF WHAT COUNTRY?		
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2 NO	ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN NO 11 yes, specify Cuben, Mexican, Puerto 1				14. RACE — American ind Black, White, etc. Specify: White		
PLETED	15. OECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12)	(Specify only highest grade completed)			DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			maker		
E COMPL	17. FATHER'S NAME (First, Middle, Last) Edward Spenc	er			18. MOTHER'S N	AME (First, Mic	ddle, Maiden Surname)	Surname)		
TO B	19a. INFORMANT'S NAME (Type/Print) Thomas E. Spath					Aoute Number		y or Town, State, Zip Code) NY 11201		
1	20e. METHOD OF DISPOSITION  1  Burial 2  Gremation 3  Re 4  Donation 5  Other (Specify)		ACE AND DATE OF DISPOSITION (Name of y, crematory or other place)			DATE 20c. LOCATION — City or Town, State				
	21. SEGMATURE OF BUSINERAL SERVICE I	HOPPINE RODALD V	Wade, Dir 74/7/93		AND ADDRESS OF F		State Anat			
		policial and the second								
	23 PART I. Enter the diseases, or shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Setic	od the death. Do each lina.  Shoc.	k.						
ERTIFICATION	IMMEDIATE CAUSE (Final disease or condition	a. Due to (DR AS of the Country of t	Shoc	k., n:				et, Approxim		
N: MEDICAL CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events	a. DUE TO (DR AS a DUE TO (OR AS a d	SACONSEQUENCE O	к. п: п:	node of dylng, suc	ch an cardle		et, Approxim		
MEDICAL	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other algnificant conditions.	a. DUE TO (DR AS a DUE TO (OR AS a d	Shoc A CONSEQUENCE O A CONSEQUENCE O A CONSEQUENCE O but not resulting	F): in the underlyi	ng cause given in	Part I. 2	44. WAS AN AUTOPSY PERFORMED?	Approximinterval E Onset an  24b. WERE AUTOPSY F AMALABLE PRIOR COMPLETION OF OF DEATH?		
PHYSICIAN: MEDICAL	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST  PART II. Other algnificant conditions are conditions.  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF CEATH  1 Netural 5 Pending	a. DUE TO (DR AS  DUE TO (DR AS  DUE TO (DR AS  DUE TO (OR AS  DO CONTROL TO (OR	SACONSEQUENCE O  A CONSEQUENCE O  A CONSEQUENCE O  Dut not resulting	P: F):  The underlyi  The unde	node of dylng, suc	Part I. 2	44. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FAMILABLE PRIOR COMPLETION OF DEATH?		
BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death)  PART if. Other aignificant conditions of the cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST  PART if. Other aignificant conditions of the cause	a. DUE TO (DR AS  DUE TO (DR AS  DUE TO (DR AS  DUE TO (OR AS  DUE TO (OR AS  DO CONTRIBUTING TO GENTLE  HOSPITAL 1	Shoc  A CONSEQUENCE O  A CONSEQUENCE O  A CONSEQUENCE O  but not requiting  patient 3 DOA  28b. Till IN.	F):  F):  in the underlyi  OTHER: 4   Nursing Ho JURY M 1	ng cause given in	heck only one)  6  Other (  286, DESC)	44. WAS AN AUTOPSY PERFORMED?  1 YES 2 NO	Approximinterval B Onset an  Onset an  24b. Were AUTOPSY F AMALABLE PRIOR COMPLETION OF OF DEATH?  1 YES 2   JRED		
ETED BY PHYSICIAN: MEDICAL	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other aignificant conditions are under the condition of the condition of the cause. Examiner?  1	a. DUE TO (DR AS A DUE TO (DR	SACC A CONSEQUENCE OF A	P: F):  F):  The underlyi  26.  OTHER: 4   Nursing Ho BE OF 28c. If JURY M 1   street, factory, off	ng cause given in	heck only one)  6  Other (  28d. OESC)	As. WAS AN AUTOPSY PERFORMED?  I YES 2 NO  Specify)  RIBE HOW INJURY OCCU  TOWN, State)	Approximinterval E Onset an On		
BY PHYSICIAN: MEDICAL	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other aignificant conditions are under the condition of the condition of the cause. Examiner?  1	a. DUE TO (DR AS  DUE TO (DR AS  DUE TO (DR AS  DUE TO (OR	SACC A CONSEQUENCE OF A	P: F):  F):  The underlyi  26.  OTHER: 4   Nursing Ho BE OF 28c. If JURY M 1   street, factory, off	ng cause given in	heck only one)  6 Other (  281. LOCAT City or	As. WAS AN AUTOPSY PERFORMED?  1 YES 2 NO  Specify)  RIBE HOW INJURY OCCI.  ROW, Stete)  NO (Street and Number of Town, State)	Approximinterval E Onset an On		



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

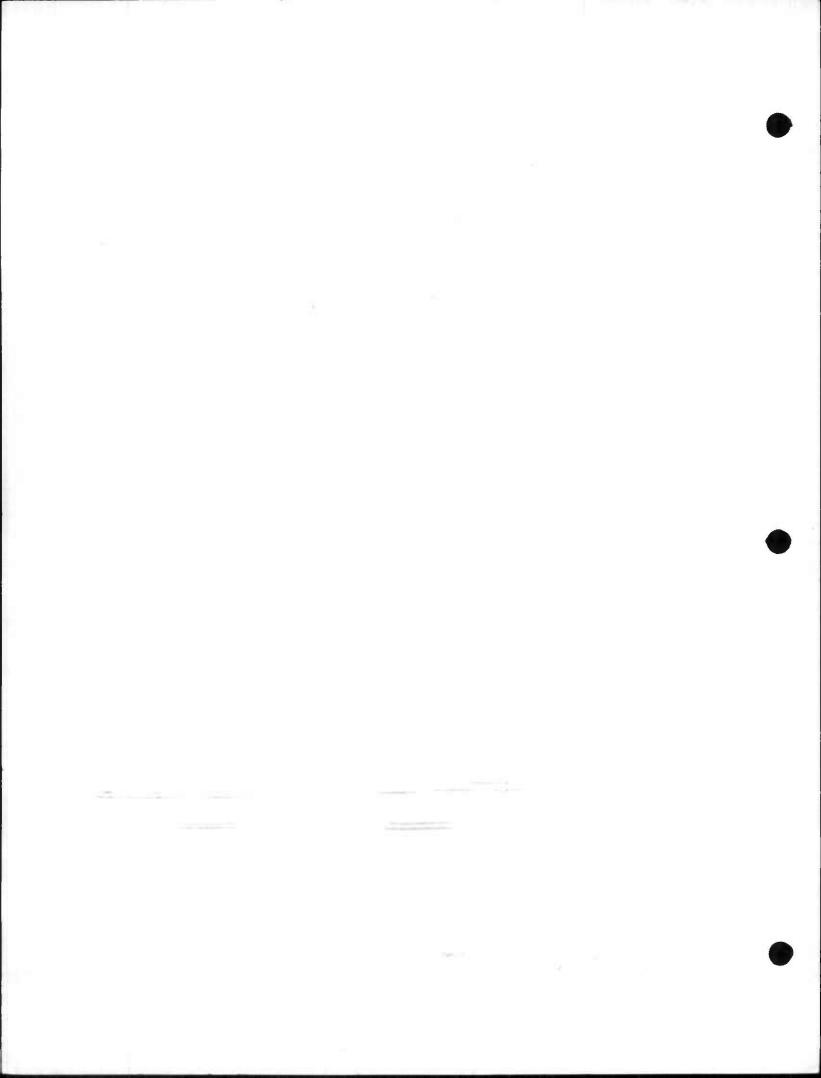
	1 - FOR STATE REGISTRAR	STATE OF MARYL		IENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIEN		03330		
-	1. DECEDENT'S NAME (First, Middle, Last)  ARE	Sim	ms		2. DATE OF DEATH DO		3. TIME OF DEATH A		
- 3	4. SOCIAL SECURITY NUMBER			UNDER 1 YEAR IF UNDER 24 HRS	7. DATE OF BIRTN	7. DATE OF BIRTN 8. BIRTHPLACE (State or Formice			
	217-16-0493  9e. FACILITY NAME (If not institution, give str	.6	Tha.		12/20/23				
DIRECTOR	SOUTHERN MAR RESIDENCE OF DECEDENT	1 1	Spital	alinton,		PRIM	DE GEDREE		
IREC	10a. STATE 10b. COUNTY Maryland Princ	- CI-		OWN OR LOCATION			10d. INSIDE CITY LIMITS?		
	100. STREET AND NUMBER	e George's	0xo	n Hill		40- 0171751	1 🔀 YES 2 🗌 NO		
FUNERAL	2166 Alice Avenu	e, Apt. #3		20745		U.S.			
J.	11, MARITAL STATUS	12. WAS DECEDENT EVER II FORCES? 1 YES	U.S. ARMED	13. WAS DECENDENT OF HISI If yes, specify Cuban, Max			RACE — American Indian, Black, White, etc.		
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR D		1 YES 2 NO Spe			Specify: Black		
	15. DECEDENT'S EDUC. (Specify only highest grade of	ATION	16a. OECEDENT'S USL	IAL OCCUPATION	16b. KIND OF BUS	INESS/INDUST	TRY		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	IIIe. Do NOT use rei						
OMP	17. FATHER'S NAME (First, Middle, Last)		Homemake						
S	George Simms				NAME (First, Middle, Malden Le Brown	Sumame)			
) BE	19a, INFORMANT'S NAME (Type/Print)		19b. MAILING ADI	DRESS (Street and Number or Rur		n, State, Zip Coo	de)		
5	Deborah Simms		4010 31	d Street, S.	E., Washingt	on, D.	.C. 20032		
	20a METHOD OF DISPOSITION 1 D Burlel 2 Cremetion 3 Remove	val from State 20b	PLACE AND DATE OF D	SPOSITION (Name of place)	DATE 20c. LO	CATION — City	or Town, State		
	4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LICE	WE WEE	shington	Nat'1. Cemete	ry 3/23/93	Suitl	and, MD		
	Liver H	émmine =	<b>#947</b>	Robert G. M 1661 Good H					
	23. PART I. Enter the diseases, or co shock, or heart feilure. L.	omplications that caused	the deeth. Do not e	enter the mode of dying, a	uch as cerdiac or reepi	ratory erreat,	Approximate Interval Between		
	IMMEDIATE CAUSE (Final disease or condition	100	011111				Onset and Death		
	resulting in death)	DUE TO (OR AS A	CONSEQUENCE OF:	ca_					
z			,						
AT 10	If any, leading to immediate cause, Enter UNDERLYING								
FIC	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):						
CERTIFICATION	resulting in death) LAST						į		
	PART II. Other significent conditions	contributing to death b	ut not resulting in th	e underlylog ceues gives	In Pert I. 24a, WAS AN	ALITOREY	24b. WERE AUTOPSY FINDINGS		
MEDICAL			at the researching in the	is allustrying course given	PERFOR	MED?	AMILABLE PRIOR TO COMPLETION OF CAUSE		
밁					1 _ YES 2	[] NO	OF DEATH?		
Z							10 100 10 10		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	01	26. PLACE OF GEATN (	Check only one)				
ΗΥS	1 YES 2 NO	1 Inpetient 2 ER/Outp 26s. DATE OF INJURY		Nursing Nome 5 Residenc	6 Other (Specify)  26d. OESCRIBE NOW IN				
ВУ Р	1 Natural 5 Pending	(Month, Day, Year)	INJURY	WORK?  M 1 YES 2 NO	280. DESCRIBE NOW IN	JUNY OCCUME	:0		
	3 Suicide 6 Could not be	28e. PLACE OF INJURY building, stc. (Spec	— At home, farm, street	t, factory, office	28f. LOCATION (Street a City or Town, State)	nd Number or R	lural Route Number,		
	4 Homicide determined				Oily or lown, State)				
COMPLETED				the time, data and place, and d my opinion, death occured at ti			use(s) and manner as stated.		
	200 AUGMATURE AND STILL OF CERTIFIED				1	204 DATE SI			
Щ	29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year)								
00	now	2/11/2	Allen	du/ 1)-2	V 535	<b>&gt;</b> 3	BI 1819		
TO BE	30. NAME AND ADDRESS OF PERSON WHO LAX MI BE RULA	COMPLETED CAUSE OF DEA		du/ 1)-2	Y535	<b>&gt;</b> 3	3 1893 1 2073		

BALTIMORE, MARYLAND 21215-0020	nours after death. Page 6 may be retained by the hospital or attending physician.	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hospital or attending physician.	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the formours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

es 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hoss TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

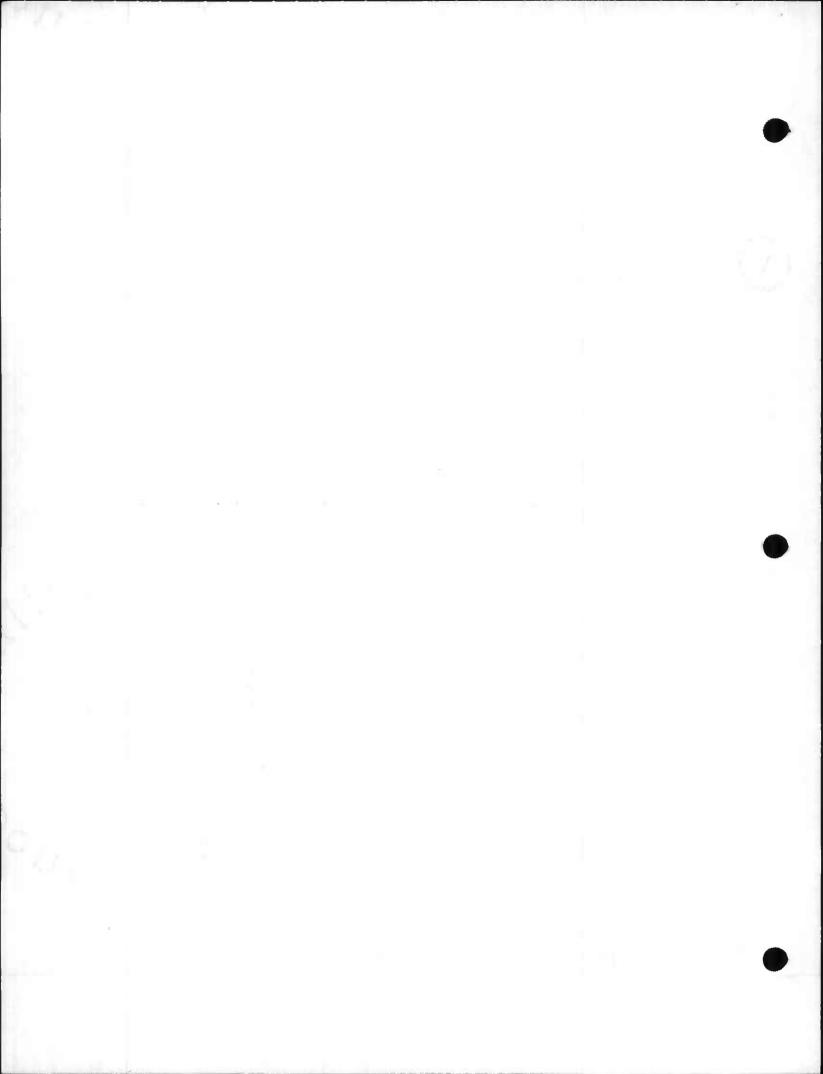
IMPORTANT: If Nem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE REGISTRAR	STATE OF MARYLA		ENT OF HEALT		NTAL HYGIEN	E	
1. DECEDENT'S NAME (First, Middle, L.	ast)				DATE OF DEATH		3. TIME OF DEATH
Daries		Tallev	,		04 01		0751
4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In				DATE OF BIRTH (Month, Day, Year)	S. BIRT	THPLACE (State or Foreign
N/A	1 № M 2 🗆 F	YRS.	DAYS HOURS	B MIN.	7-29-91	Ma	ryland
9e. FACILITY NAME (If not institution, g	ive street and number)	9b.	CITY, TOWN OR LOCA	TION OF DEATH	1	9c. COUNTY OF	
Johns Hopkins RESIDENCE OF DECEDENT 100. STATE 10b. COL Maryland	Hospital		Baltimo	re			
10e. STATE 10b. COL	JNTY	10c. CITY, TO	WN OR LOCATION			:	10d. INSIDE CITY
		Balt	imore				LIMITS?
10e. STREET AND NUMBER 2407 Loyola  11. MARITAL STATUS 1 12 Nover Married 2 Married			10f. ZIP CC	DOE		10g. CITIZEN OF	WHAT COUNTRY?
2407 Loyola	Northway apt	: 101	212	15	_	US	Δ
11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DECENDENT If yes, specify Cu	OF HISPANIC O	ORIGIN? (Specify Yes	or No.— 14. RAG	CE — American Indian, ck, White, etc.
3 Widowed 4 Divorced	IF YES, GIVE WAR OR DAT	ES	1 TES 2 N		derio Mican, etc.)		c#y: Black
15. DECEDENT'S	FOUCATION						DIGCK
(Specify only highest g	rade completed)	(Give kind of work iffe. Do NOT use reti	done during most of wor	rking	18b, KIND OF BUS	INESS/INDUSTRY	
Elementary/Secondary (0-12) N/A	College (1-4 or 5+)	N/A					
15. DECEDENT'S (Specify only highest g Elementary/Secondary (0-12) N/A 17. FATHER'S NAME (First, Middle, Last)				THEOLO MARIE	First, Middle, Maiden		
	ey				rist, Middle, Malden : ce Selli	,	
19e. INFORMANT'S NAME (Type/Print)	-	19h MAII INC ADD	PRESS (Street and Numb				
Cynthia Alex	ander	1					
20a. METHOD OF DISPOSITION	200 5	PLACEAND DATE OF DI	Brighton	St.		ATION — City or T	
1 & Burlet 2 Cremetton 3 F	Removal from State camat	ery, crematory or other p	laca)	į			own, State
21. SIGNATURE OF FUNERAL SERVICE	LICENSEE	stern St	22. NAME AND ADDR	RESS OF FACILIT	4-6 Bal	o Md	
1 Calle	C. Wangla	/	Chatman			cal Hom	16
23. PART I. Enter the diseases,		w	1701 MC	Cull 1 of	st.		
immediate cause (Final disease or condition resulting in death)	a. SEPSIS  DUE TO (OR AS A C	CONSEQUENCE OF):					Onset and Dest
Sequentially list conditions, if any, isoding to immediats cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	C. DUE TO (OR AS A C						
	_ d						
BURNS RIGHT FOO		t not resulting in th	e underlying cause	given in Pari	24a. WAS AN / PERFORI	MED?	b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 \( \square\) NO
25. WAS CASE REFERRED TO MEDICAL							
EXAMINER?	HOSPITAL:	ОТ	26. PLACE OF HER:	DEATH (Check o	only one)		
1 YES 2 NO	1 Inpatient 2 X ER/Output	ient 3 🗆 DOA   4 🗆	Nursing Home 5 🗆				
27. MANNER OF DEATH  1 Natural S Pending	266. DATE OF INJURY (Manth, Day, Year) U	Z8b. TIME OF	28c. thJURY AT WORK?	W 1	th hot wat	JURY OCCURED	Subject scalde
2 Accident Investigation	m 04 01 199	3 0000		X." IS:	ubiect -	assau Li	ed
3 Suicide 6 Could not	a amaning, trus (opposity	1)		28f	. LOCATION (Street ar City or Town, Stete)	1820 Guill	Route Number, ford Ave.
		H			****	Balto.Ci	
29e. CERTIFIER (Check only one)  1 CERTIFYING PH	IYSICIAN: To the best of my knowled IINER: On the beele of exemination of	ige, death occurred at and/or investigation. In	the time, date and place my opinion, death occ	ce, end due to the	ne cause(e) end meni	her se stated.	a) and manner as stated
296. SIGNATURE AND TITLE OF CENTS							
ACIONA Pol	411) 11 -64	MD		CENSE NUMBER		29d. DATE SIGNE	O (Month, Day, Year)
36. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUSE OF DEAT	H (ITEM 27) (Nov. Prins		.C.M.	Ε.	04 (	1993
Donald G. Wri	gh + MD	111 Peni	ı Street	Bal	timore.	Maryla	and 2120
ADD 08 1993	La Saide D.						



	_	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO.									
	1	DECEDENT'S NAME (First, Middle, Lest)     MARY	Т			2. DATE OF DEATH MONTH PAR APRIL 5, 1993			OF DEATH		
DIVISION OF VITAL RECORDS, P.O. BOX 68760,  HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the funeral hospital by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the funeral hospital by the funeral hospital by the funeral director, page 5 should be detached for use as the funeral page 1, 2, 3 should within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.		4. SOCIAL SECURITY NUMBER 245 - 54 - 3685	5. SEX 6. AGE (1	In yrs. lest birthday)	MONTHS DAVE MOURS AND (Month, Day,			8. BIRTHPLACE (State or Foreign Country)			
	BE COMPLETED BY FUNERAL DIRECTOR	THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH  BALTIMORE CITY			BALTIMORE CITY		
		ир.			TOWN OR LOCATION				10d. IHSIDE CITY LIMITS? 1 V YES 2 NO		
		10a, STREET AND NUMBER	AND NUMBER			107. ZIP CODE 21213			109. CITIZEN OF WHAT COUNTRY?		
		11. MARITAL STATUS  1)C Never Married 2 Merried  3 Widowed 4 Divorced	12. WAS DECEDENT EVER IH U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES			13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify V If yea, specify Cuban, Mexican, Puerto Rican, etc.)  1  YES 2 N NO Specify:					
		15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)		(Give kind of a life. Do NOT us	USUAL OCCUPATION of done during more retired.)	ON isl of working	16b. KIND OF B	USINESS/IHDUS		<del>ue k</del>	
		Disabl 17. FATHER'S HAME (First, Middle, Leet) Henry Turnage				18. MOTHER'S HAME (First, Middle, Maiden Surneme) LUCY Taylor					
	TO B	19a. MFTHOD OF DISPOSITION  19b. METHOD OF DISPOSITION  19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  1706 E. Federal St./Baltimore, MD 21213									
	Collich	1) Observed 2 Cremation 3 Removal from State   Donation 5 Other (Specify)									
	AN: MEDICAL CERTIFICATION	WM C. MARCH F.H./1101 E.NORTH AVE.  23. PART I. Enter the diseases, pr complications that caused the desth. Do not enter the mode of dying, such as cardiec or reapiratory arrest, shock, or heart feliure. List only one cause on each line.  Approximate interval Between Onset and Dest									
		disease or condition resulting in death)  Sequentially list conditions,	DUE TO (OR AS A CONSEQUENCE OF):  Deep Vein Thrombosi's					1	30 mix		
		Sequentially list containing, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST									
		PART II. Other algnificant condition	s contributing to death b	ut not resulting	in the underlyin	g cause given in	Part i. 24a. WAS / PERF	AN AUTOPSY ORMED?	MAILAB	UTOPSY FINDINGS LE PRIOR TO THO OF CAUSE	
		25. WAS CASE REFERRED TO MEDICAL			26 96	ACE OF DEATH (C	hank only one)			S 2 NO	
	PHYSICIAN:	EXAMINER?  1VI YES 2 NO  27. MANNER OF DEATH	HOSPITAL: 1   Inpetient 2 DER/Outpetient 3 DOA 4   Hursing Home 5   Residence 8   Other (Specify)  28b. DATE OF IHJURY 28b. TIME OF INJURY WORK?  WORK?								
	ED BY	1 Heturel 5 Pending Investigation 2 Accident 3 Suicide 6 Could not be 4 Homicide determined 28e. PLACE OF INJURY — At home, farm, street building, etc. (Specify)			M 1 🗆	M 1 YES 2 HO			treet end Number or Rural Route Number, Stete)		
	COMPLET	29a. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated, one)  2 MEDICAL EXAMINER: On the best of examplaction end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner as stated.									
TO THE HOSPI TO THE FUNER be filed within	TO BE CC	290. BIGNATURE AND WILE OF CERTIFIES MD 290. DATE BIGNED (Morge, City, 10ar)									
^		30. NAME AND ADDRESS OF PERSON WHO	A. Lex Le		ahns	Hopk	ins He	2501	w		

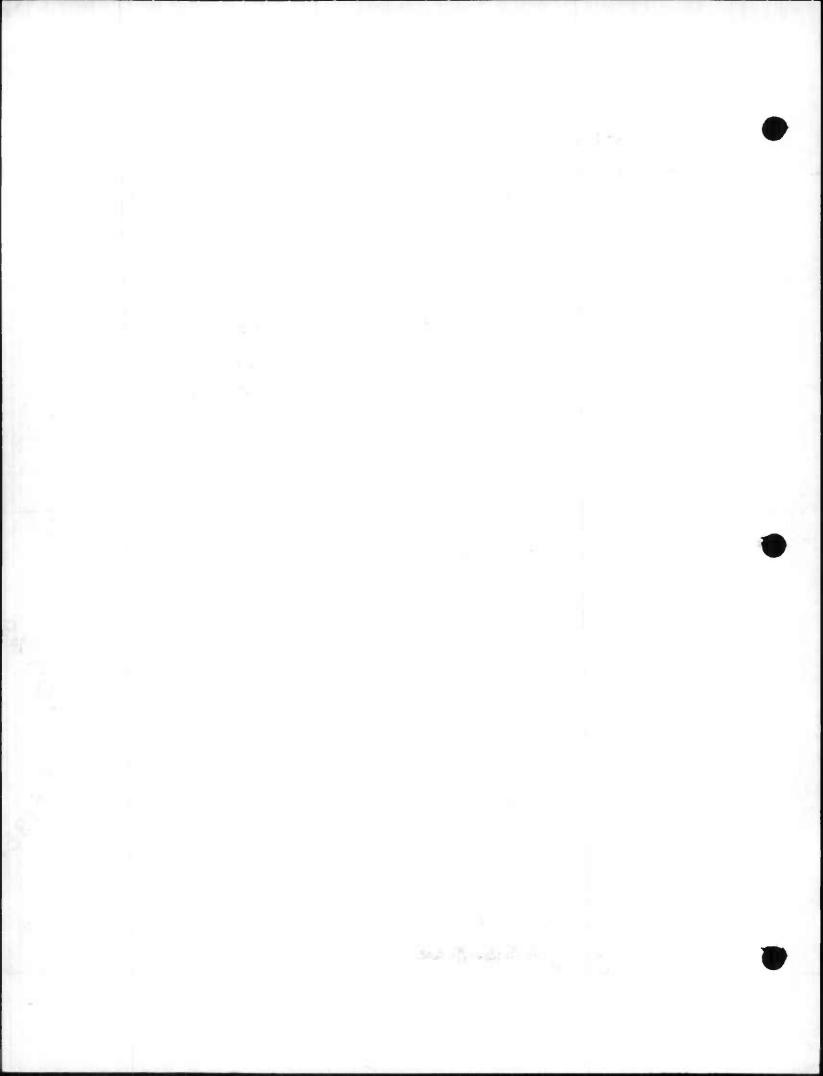
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		1 - FOR STATE REGISTRAR	STATE OF MARYL			HEALTH AN		AL HYGIENE REG. NO.		
	1	1. DECEDENT'S NAME (First, Middle, Last)  GIUSE	PPE	TEST	A		2. DAT	TE OF DEATH	- 93	3. TIME OF DEATH 09504 M
-	1	4. SOCIAL SECURITY NUMBER 125-46-1123	5. SEX 6. AGE (	n yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAY		(Mo	E OF BIRTH	7 S	HTHPLACE (State or Foreign unity). 1 C 1 1 y
2, 3 should	OR	St. YOSEPHIA	HOSPIFA	16		N OR LOCATION O	OF DEATH		9c. COUNTY O	ALTO,
permit. Pages 1,	DIRECTOR	100. STATE 10b. COUNTY Maryland	Y		y, TOWN OR LO					10d. INSIDE CITY LIMITS?
it permit.	AL AL	100. STREET AND NUMBER 1260 Meridene Dr	i vo		1 (111101	101. ZIP CODE 21239				1) YES 2 NO
physician. burial-transit	FUNER	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DO	2 NO	If yes,	ECENDENT OF NI specify Cuben, M	lexican, Puert	IN? (Specify Yes of Picen, etc.)		ACE American Indian, lack, White, etc.
attending se as the	ED BY	3 Wildowed 4 Divorced  15. DECEDENT'S EDU (Specify only highest grade	CATION	16a. DECEDENT'S		TES 2 X NO S		5b. KIND OF BUSI	Wh	nite
the hospital or atte detached for use once.	COMPLET	Elementary/Secondary (0-12) 4 YYS.	College (1-4 or 5+)	Warehou.	se retired.)	most of working		Acme Ma	arket	
ed by the hor	BE CO	17. FATHER'S NAME (First, Middle, Last) Salvatore Testa				Gius	ерра	Matassa Matassa	a .	
ay be retained page 5 should be notified	10	Lucia R. Testa		1260	Merider	et and Number or F				
director, pa		20a. METHOD OF DISPOSITION  1 Burlel 2 Cremation 3 Rem  4 Denation 5 Other (Specify)	tombrent cem	PLACE AND DATE etery, cremetory or o	ther place) Lley Maus	soleum	4-10-93		nium, Md.	
ter death. Pag the funeral di yval.		21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE ROY H. Ca	ther		and address o		5305 Harf	ord Rd.,	Balto.,Md.21214
within 24 hours at spletely filled in by cremation, or remorent, the medical		23. PART I. Enter the diseases, or shock, or heart feliure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Puls	I the death. Do nich ilne.	ary	mode of dying,	such as ce	rdiac or reapin	atory arrest,	Approximate interval Between Onset and Death
he death certificate be executed the attending physician and com Mentai Hygiene prior to burial, Ijury, or other traumatic en	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c	CONSEQUENCE O						
signed by Health and Ws any Ir	MEDICAL	PART II. Other significent condition	a contributing to deeth b	ut not resulting	in the underly	ing ceuse give	n in Part I.	24s. WAS AN A PERFORM	MED?	24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
SICIAN: The law requestrificate has been to the State Dept. of the State 23 should be on them 23 should be on them 23 should be on the or the	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO	HOSPITAL: 1   Inpatient 2   ER/Outp	miles a 🗆 DOA	OTHER:	PLACE OF DEATH				
NG PHYSICIA feer this certife eath with the marked, or	РНУ	27. MANNER OF DEATN 1	28e. DATE OF INJURY (Month, Day, Year)	26b. TIM	E OF 28c.	ome 5 Reside	28d. D	ESCRIBE HOW IN	JURY OCCURED	de
OR ATTENOING I DIRECTOR: After hours after death Item 28 is man	TED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Nomicide datermined	28e. PLACE OF INJURY building, etc. (Spec	— At home, ferm,	street, factory, o	ffice	281. LC	CATION (Street an ty or Town, State)	nd Number or Flur	al Route Number,
HOSPITAL OR A FUNERAL DIREC WITHIN 72 hours TANT: If Item	COMPLE	one)	CIAN: To the best of my knowl R: On the basis of examination							e(s) and manner as stated.
TO THE HOSPI TO THE FUNEF Be filed within IMPORTANT:	BE	296. SIGNATURE AND TITLE OF CERTIFIED	20	izon	M	29c, LICENSE	NUMBER 64	92	29d. DATE SIGN	ED (Month, Day, Year)
(	TO	30. NAME AND ADDRESS OF PERSON WAS	COMPLETED CAUSE OF DEA	ON -	et.	Breps	12	ospi	tall	Towson ma
9		APR 08 1993 9	32. REGISTRAR'S SIGN.	ATURE /	V			0	/	

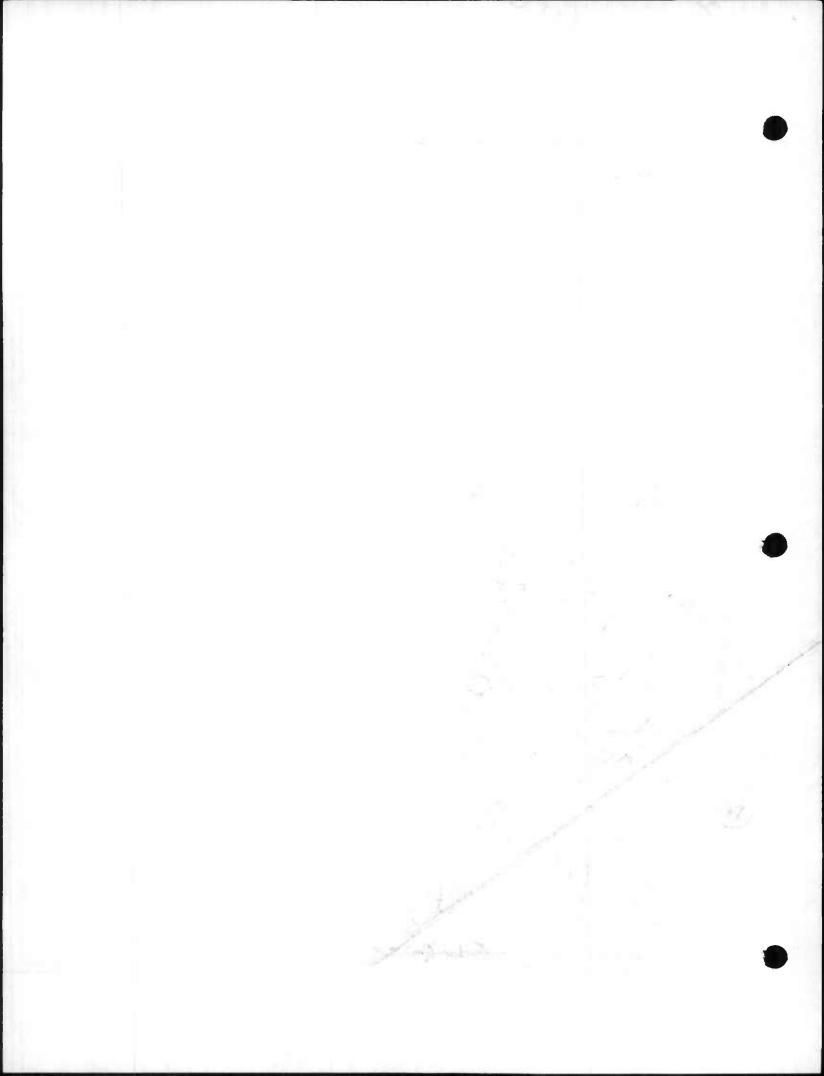


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	T. Decepting NAME (First Micon List)		CARMELO	TRIN	GALI 2. DA	TE OF DEATE 14/93 HTH, DAY	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 220-03-1947	X⊠ M 2 □ F 83	YRS. MO	UNDER 1 YEAR THIS DAYS		0.08.09 I	ABIPITHPLACE (State or Foreign Country) ARYLAND
TOR	99. FACILITY NAME (If not institution give s  A / A / A / A / A / A / A / A / A / A	eph Has	P. Val		TOWSON	9c. COUNT	BALTIMORE
DIRECTOR	100. STATE 100. COUNTY MARYLAND	BALTIMORE	10c. CITY, TO	PIKE:	SVILLE		10d. INSIDE CITY LIMITS? 1 \( \text{YES 2000 NO} \)
FUNERAL	4 ESTATES COURT	APT. 310	5	101	21208		N OF WHAT COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES	IN U.S. ARMEO	If yes, sp	ENDENT OF HISPANIC ORK ecity Cuben, Mexican, Puerl ZXXNO Specify:	GIN? (Specify Yes or No. 1	t. RACE — American Indian, Black, White, etc. Specify: WHITE
once.	15. OECEOENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	16a. DECEDENT'S USE (Give kind of work life. Do NOT use re	done during mo tired.)	st of working	6b. KIND OF BUSINESS/INDUS	STRY
OMP	12 17. FATHER'S NAME (First, Middle, Last)		ASSEMBLY	PLANT V		GENERAL MOTO	RS
TO BE C		NGALI			GIVANN	A ZANTI	
5	190. INFORMANT'S NAME (Type/Print) LAWRENCE WOOD	(NEPHEW)				omber, City or Town, State, Zip C	
	20s METHOD OF DISPOSITION 1 N Squriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	20	b. PLACE AND DATE OF D marery, crematory or other EW CATHEDR	ISPOSITION (Na	ame of O	ATE 20c. LOCATION — CH	
	21. SIGNATURE OF FUNESIAL REPWICE LIK	). X/	1	LEROY		L C. WITZKE	FUNERAL HOMES
SATION	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING	a. SCPS S  DUE TO (OR AS )	A CONSEQUENCE OF):	enter the mo	de of dying, such as co	ardiac or respiratory arres	Approximata Interval Between Onset and Death
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF):			E	
MEDICAL C	PART II. Other eignificent condition	as contributing to death i	but not resulting in t	ne underlylng	g cause given in Part I.	24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			26. PL	ACE OF DEATH (Check only	one)	
YSI	1 TYES 2 NO	HOSPITAL: 1 Sinpatient 2 ER/Out	petient 3 DOA 4		e 5 Residence 6 Ot		
×	27. MANNER OF OEATH  1   Netural 5   Pending Investigation	(Month, Day, Year)	28b. TIME OF	WO	URY AT 28d. D	EŞCRIBE HOW INJURY OCCU	RED
	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide detarmined	26e. PLACE OF INJURY building, etc. (Spe	Y — At home, farm, streeticfly)	t, factory, office		OCATION (Street and Number or ity or Town, State)	Rural Route Number,
COMPLE	200)					cause(s) and menner as stated its and place, and due to the	cause(s) and manner as stated.
TO BE CO	29b, SIGNATURE AND TITLE OF CERTIFIED	enen M	, ):		29c. LIGENSE NUMBER	29d. DATE S	SIGNED (Month, Day, Year)
	30. NAME AND ADDRESS OF PERSON WH	762 32. BEGISTRAR'S SIGN	VALVE	Roa	d Towson	1, MD 212	04
	APR 08 1993		on Abridable				
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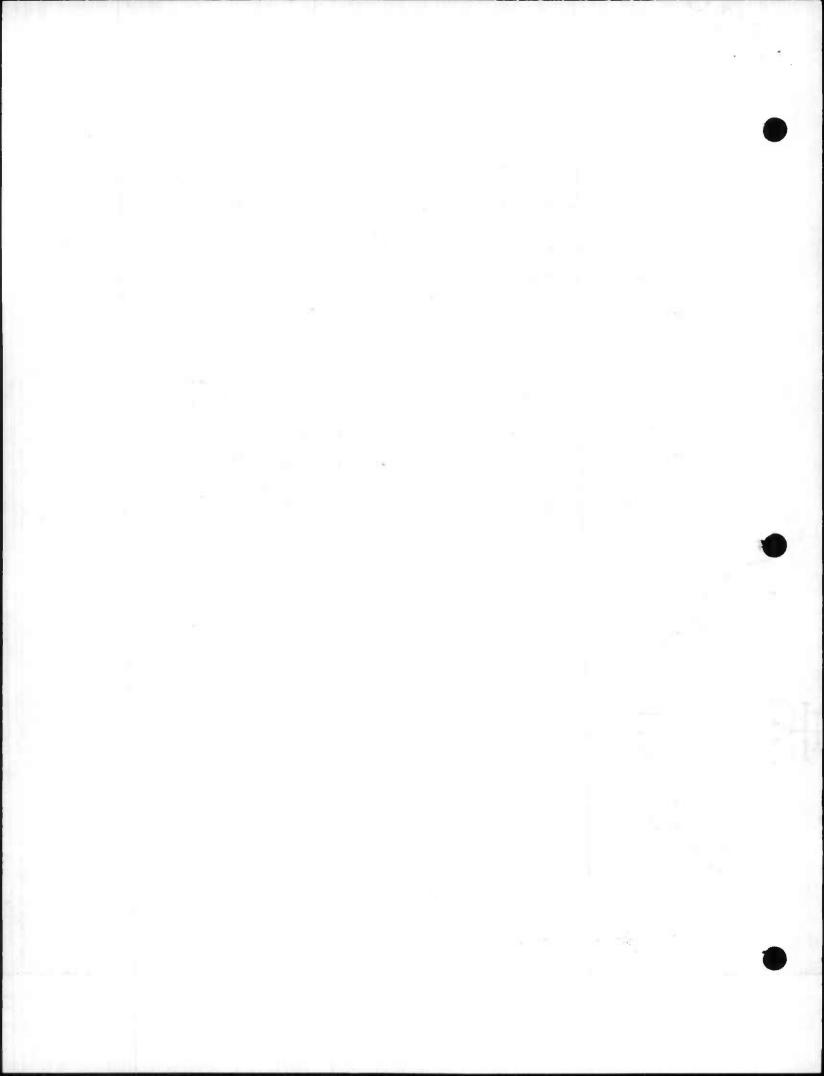
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



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		C	ERTIFICATE	0	F DEAT	TH		REG	NO

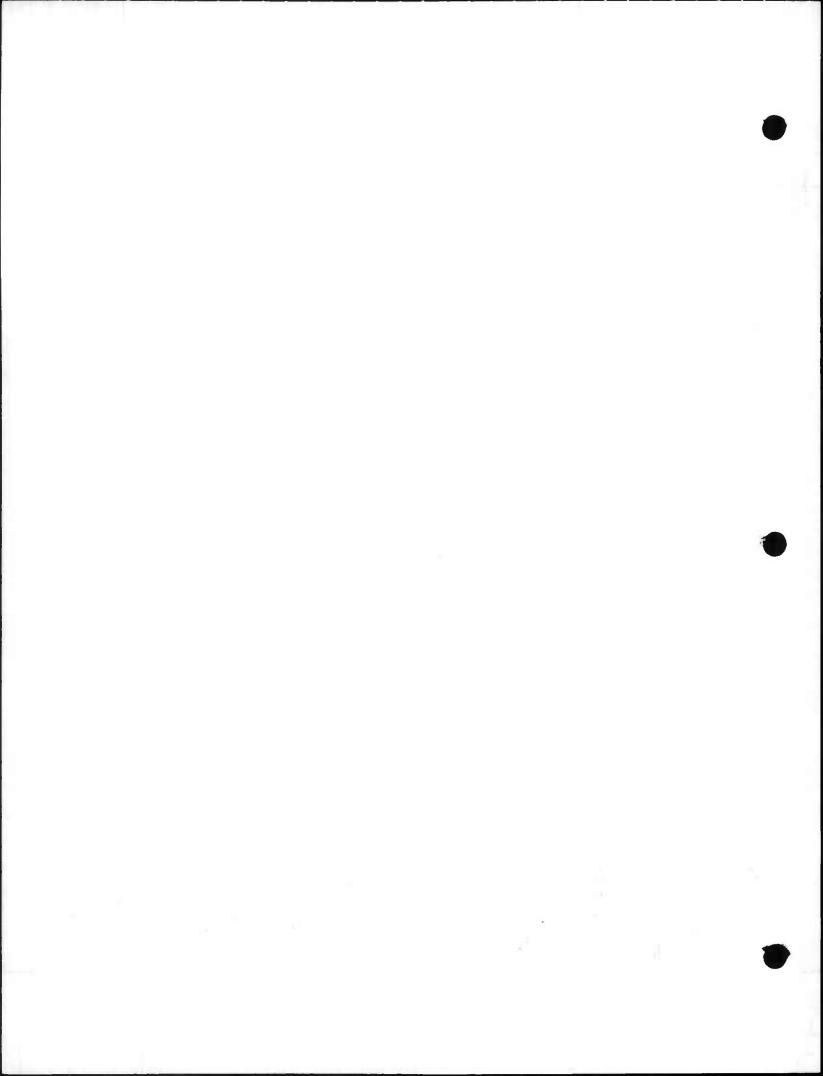
	HEGISTHAH	SENTIFIC	ALE OF DEATH	REG. NO		
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH DON'TH DA	AY YEAR	TIME OF DEATH
	Katherine L Irap	P		4 -	7 93	9-1X in
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs.		UNDER 1 YEAR IF UNDER 24 HRS.  NTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Your)	8. BIRTHPL Country)	LACE (State or Foreign
	Sa. FACILITY NAME (If not institution, give street and number)	-	. CITY, TOWN OR LOCATION OF D	4/19/2		NO.
	CT TOCOCK 110 010	. 1-			9c. COUNTY OF DEA	АТН
DIRECTOR	RESIDENCE OF DECEDENT		lowson	MD	BALT	More
l m	10e. STATE 10b. COUNTY	10c. CITY, T	DWN OR LOCATION		13	Od. INSIDE CITY
1 5	MARYLAM BATTIMORE	1	m = 0 = m			LIMITS?
	10a, STREET AND NUMBER		10f, ZIP CODE		10g. CITIZEN OF WH	
FUNERAL	HIDIO DIA					^
N N	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S.	ABMED	13. WAS DECENOENT OF HISPA	WO ODIONE D	0.5	Η.
	1 Never Married 2 Married FORCES? 1 YES 2		If yes, specify Cuban, Mexico	nn, Puerto Rican, etc.)	Black, 1	- American Indian, White, etc.
8	Widowed 4 Divorced		1 YES 2 NO Specif	у:	Specify:	
	15. DECEDENT'S EDUCATION 16a.	DECEDENT'S US	JAL OCCUPATION	16b. KIND OF BUS	SINESS/INDUSTRY	(112
	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	(Give kind of work life. Do NOT use re	done during most of working tired.)			
.   릴	TYRS.	AT I	Smot			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			ME (First, Middle, Andrew	Surname)	
E O	JACK KYLS		KAT	- KVIs		
TO BE COM	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING AD	DRESS (Street and Number or Rural	Route Number, City or Tow	n, State, Zip Code)	
2	FAMILY RICORDS	~	me as agove		, ,	
5	20a. METHOD OF DISPOSITION 20h PLAC		ISPOSITION (Name of	OATE 20c. LO	CATION — City or Town	1 State
	1) Buriet 2 Cremetion 3 Removal from State cemetery,	crematory or other	place)	43 Tic	(0)	-01.0
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	MILLY	1999		paum	IAKYLANU
	114 0		22. NAME AND ADDRESS OF FA	OF CHIMES		
5	23. PART I. Enter the diseases, or complications that caused the		2325 YORK 19	11-0A0	morium	
Z	shock, or heart fellure. List only one cause on each if  IMMEDIATE CAUSE (Final disease or condition resulting in death)  a. Respiratory DE TO (OR AS A CONSTITUTION OF EACH O	fai	: fure			Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					
4	PART II. Other algorificant conditions contributing to death but no	t resulting in t	he undarlying cause given in	Part I. 24s. WAS AN PERFOR		VERE AUTOPSY FINDINGS MAILABLE PRIOR TO
EDICAL				1 _ YES 2	0	OMPLETION DF CAUSE OF DEATH?
					1	☐ YES 2 ☐ NO
Z						
₹	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPJFAL:		26. PLACE OF DEATH (Ch	eck only one)		
S	1 YES 2 NO 1 Inpatient 2 ER/Outpatient		THER:  Nursing Home 5 Residence	8 Other (Specify)		
PHYSICIAN: M	27. MANNER OF DEATH  1 Natural 5 Pending  28e, OATE OF INJURY (Month, Day, Year)	28b. TIME O	F 28c. INJURY AT WORK? M 1 TYES 2 NO	28d. OEŞCR/BE HOW I	NJURY OCCURED	
D BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	home, ferm, stree		28f. LOCATION (Street of City or Town, State)		ite Number,
ETE						
COMPLETED	29a. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of my knowledge, one)  2 MEDICAL EXAMINER: On the basis of examination and/a					and manner es stated,
E CO	29b. SIGNATURE AND TITLE OF CERTIFIER	//	29c. LICENSE NUI		29d. DATE SIGNED (A	
2 0	high K	160	m D397		D 4/7	192
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (I					/ 13
	/					
	31. DATE FILED (Month, Day, Year)  APR US 1993  "Line Davidson—Ray	plesse				
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DIVISION OF VITAL RECORDS, I	1
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		1 - STATE OF	F MARYLAND / DEPARTI CERTIFIC	MENT OF HEALTH AND CATE OF DEATH	MENTAL HYGIENE REG. NO.	
		1. DECEDENT'S NAME (First, Middle, Last)  MARY E. URG	uhart		2. DATE OF DEATH DAY	3. TIME OF DEATH  3. 3. AM
P		4. SOCIAL SECURITY NUMBER 5. SEX $220 - 14 - 80/2$ $1 \square M 2 \square$		FUNDER 1 YEAR FUNDER 24 HRS. ONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
2, 3 should	стов	9a. FACILITY NAME (If not institution, give street and number,  INS OF EVERGRAPH WW 95	525W. Belvedony	b. CITY, TOWN OR LOCATION OF DE	PANO CE TE DE COUN	TY OF DEATH
Pages 1,	DIRECT	10a. STATE 10b. COUNTY		TOWN OR LOCATION	2) 0:4	10d. INSIDE CITY
permit.		100. STREET AND NUMBER	1	10f, ZIP CODE	10g. CITIZ	1 € YES 2 □ NO
DZU physician, burial-transit	FUNERAL	1 Never Married 2 Married FORCES?	DENT EVER IN U.S. ARMED  1 YES 2 NO VE WAR OR DATES	If yes, specify Cuban, Mexico	nn, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
	ED BY	Widowed 4 Divorced  15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S US	1 YES 2 NO Specification	16b. KIND OF BUSINESS/INDU	Specify: black
od for c	<u>     </u>	Elementary/Secondary (0-12) College (1-4 o	(GIVE KING OF WOR	k done during most of working etired.)		
be det	E COMPL	17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NA	AME (First, Middle, Maiden Surname)	
MA retain 5 sho	TO B	EVELYN STISSEH	196. MAILING AC	Century )	Ace Ba Hu,	(code) Md 21212
Page 6 may be all director, page		20a, METHOD OF DISPOSITION  1 0 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	20b. PLACE AND DATE OF I cemetery, clarification or other	DISPOSITION (Name of Park	9/8/43 Landa	ty or Town, State
death. funera		21. SIGNATURE OF FUNERAL SERVICE LICENSEE	asch	22. NAME AND ADDRESS OF FA	+ Wat	Dere -
d in by or remo		23. PART I. Enter the diseases, or complications shock, or heart failure. List only one IMMEDIATE CAUSE (Final	that caused the death. Do not cause on each line.	enter the mode of dying, suc	th as cardiac or respiratory arre	at, Approximate interval Between Onset and Death
within pletely cremati		disease or condition resulting in death)	TO (OR AS A CONSEQUENCE OF):			011001 0110 00001
and and burn	TION	Sequentially list conditions, if any, leading to immediate	TO (OR AS A CONSEQUENCE OF):			
ficat phy ne p	RTIFICATION	cause. Enter UNDERLYING CAUSE (Olsease or Injury that initiated events resulting in death) LAST	TO (OR AS A CONSEQUENCE OF):			
be death the atten Mental H	AL CER	PART II. Other significant conditions contributing	to death but not resulting in	the underlying cause given in	Part I. 24e. WAS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS
that the day the and by	EDIC				PERFORMED?	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
De De	SICIAN: M	25. WAS CASE REFERRED 20 MEDICAL		26. PLACE OF DEATH (Ch		1 TYES 2 NO
는 용용 등	rsic	EXAMINER?  1 YES 2 NO 1 Inpetient		Nursing Home 5 - Residence		
子芸書	у РНУ	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	th, Day, Year) 28b. TIME C	PF 28c. INJURY AT WORK? M 1 YES 2 NO	28d. DESCRIBE HOW INJURY OCCU	JRED
TTENDI CTOR: A sher di 28 is	ETED B	3 Suicide 28e. PLAC	CE OF INJURY — At home, farm, streing, etc. (Specify)	et, factory, office	281. LOCATION (Street and Number of City or Town, State)	er Rural Route Number,
OR STATE	COMPLE	29e. CERTIFIER (Check only one) 2 USERTIFYING PHYSICIAN: To the been cone)			to the cause(s) and menner as state	
A THE	BE	290. SIGNATURE AND FITUE OF CENTIFIER		MD 28c. LICENSE NUM		SIGNED (Month, Day, Year)
₽ ₽ 2 3 \$	5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED OF	CAUSE OF DEATH (ITEM 27) (Type, PV	(272 Daish	to toron Po	#7h
3		31. DATE FILED Month Day, Year) APR 08 1993	TRAP'S SIGNATURE	The same	The state of the s	n 201



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MARYLAND 21215-0020	leath Pane 6 may he retained by the hospital or attending shadeled
BALTIMORE, I	Pane 6 may he
BALT	nire after death
68760,	ecided within 2s ho

DIVISION OF VITAL RECORDS, P.O. BOX HOSPITAL OR ATTENDING PHYSICIAN: The law

1 - FOR STATE REGISTRAR REG. NO.

2. DATE OF DEATH DAY-6-93 FAR MONTH CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) Milan Vuitch, 3. TIME OF DEATH MILAN M VUITC 850 A . 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign HOURS 217 36 5875 1 🖳 M 2 🗌 F YRS. 78 1-15-1915 Ada, Yugoslavia permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Holy Cross Hospital Silver Spring Montgomery Co. RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery County Silver Spring 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1225 Edgevale the burial-transit Road 20910 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-It yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 1 Never Married 2 Married 1 YES 2 NO Specify: BY 3 Widowed 4 Divorced No White 35 COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KINO OF BUSINESS/INDUSTRY esn (Specify only highest grad Ď Elementary/Secondary (0-12) College (1-4 or 5+) Medicine Physician 12+ detached 12+ once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) director, page 5 should be Ħ Milan Vuitch BE Elena notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 2 Florence Vuitch 3330 N. LeisureWorldBlvd#304.SilverSprings.MD20906 99 20e. METHOD OF DISPOSITION
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must 4 Constion 5 Other (Specify) 21. SIGNATURE OF FU ERAL SERVICE LICENT Ronald Wade, Dir 22. NAME AND ADDRESS OF FACILITY State Anatomy Board examiner the funeral 4/6/93 655W.BaltimoreSt,Balto,MD 21201 medical 23/PART I. Enter the diseases, or complications that ceused the deshock, or heart failure. List only one cause on each line. or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, filled in by **Approximata** Interval Between 8 IMEDIATE CAUSE (Final **Onset and Death** the attending physician and completely fille Mental Hygiene prior to burial, cremation, the disease or condition resulting in death) relmonary rdio event, traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING Mumoria CAUSE (Disease or Injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS been signed by the pt. of Health and N shows any Inj AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 TYES 2 NO PHYSICIAN: has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item r this certificate h **EXAMINER?** HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA OTHER: 1 YES 2 NO 4 🗌 Nurs ne 5 🗆 Residence 6 🗆 Other (Specify) 6 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? marked, 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation м After to 1 YES 2 NO B 2 Accident 28e. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 60 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be DIRECTOR: 28 4 Homicide Item 29e. CERTIFIER (Check ank) 1 CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. FUNERAL I IMPORTANT: If 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 물물을 Sixtuara D36980 28 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 32, BECHSTRAR'S SIGNATURE APR - 8 1993

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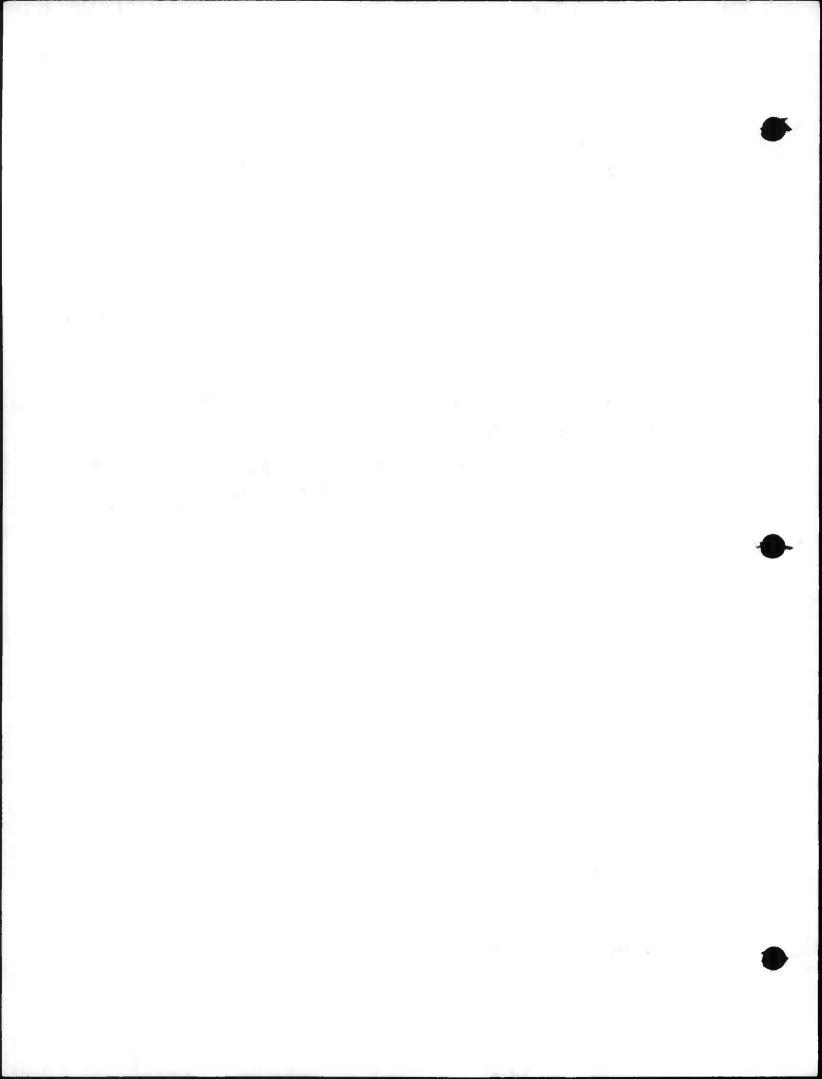
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	į
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	1. DECEDENT'S NAME (First, Middle, Last)					OF			E OF DEATH	v		3. TIME OF DEATH
		igand						MON	TH DA	17	93	19:05 %
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I	est birthday)	IF UNDER 1	YEAR DAYS	IF UNDER 24 HRS.	7. DATE	OF BIRTH		s. BIRTHE Country	LACE (State or Foreign
	214-01-7385	1 □ M 2 🂢 F	87	YRS.	MONTHS C	MYS	HOURS MIN.	Ap	ril 1,	190	Ma	ryland
_	90. FACILITY NAME (If not institution, give s						OR LOCATION OF O		-1.	9c. COU	NTY OF OE	ATH
DIRECTOR	Union Memorial	. Hospital	-		Ва	Ltı	more, Mo	k	City	_		
EC	10a. STATE 10b. COUNT	Υ		10c. CITY	r, TOWN OR	LOCAT	TON					10d. INSIDE CITY
1	Maryland -			В	altim	ore	≘					LIMITS?
A P	10e. STREET AND NUMBER					101	. ZIP CODE			10g. CIT		HAT COUNTRY?
FUNERAL	3119 Lawnview Ave	2.					21213			U.	S	Α.
12	11. MARITAL STATUS	12. WAS DECEDENT FORCES? 1	EVER IN U.S. A	RMED			ENDENT OF HISPA					- American Indian, White, atc.
BY	1 Never Married 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE W		ur.	10	YES	2 NO Specific	ly:	rucan, atc.)		Specify	
ED	15. DECEDENT'S EDU	CATION	140.0	ECEDENT'S	Hellar occ	IDATIO	NA		b. KIND OF BUS			WIIICE
ETE	(Specify only highest grade Elementary/Secondary (0-12)	completed)		Give kind of w	rork done dur			"	D. KIND OF BUS	INESS/INL	JUSTRY	
교	NA NA	Conege (1-4 of 5 +)					9		State	of N	Marvl	and
COMPL	17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NA	ME (First,				
w	John Muller								Birch	,		
0	19a. INFORMANT'S NAME (Type/Print)						nd Number or Rural					
은	Edgar Weigand (B	rother-in-	-Law)	2881	Ches	ter	cfield A	ve.,	Baltin	ore,	Md.	21213
	20e. METHOD OF DISPOSITION  1. Buriel 2 Cremetion 3 Rem	ouni from State	20b. PLACE	AND DATE O	F DISPOSITI	ON (Na	me of	DA	TE 20c. LOC	CATION —	City or Tow	n, State
	1 A) Buriel 2 Cremetion 3 Removal from Stata   Cametery, cremetory or other place   Dulaney Valley Mem. Gardens 4/7   Timonium, Md.											
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  Schimunek Funeral Home											
	1 A Toologs	LANGE	211		33	31 DTU	nunek Fi Brehms :	uner	al Home	more	- MA	21212
	23. PART I. Enter the disesses, or	complications that	ceused the d	leeth. Dp n	pt enter th	e mo	de of dving, suc	th as car	diac or respir	atory en	est Pact	Approximate
	snock, or neart fellure.	Liet Dnly one ceus	e or eech lin	ie.								Interval Betwe
	IMMEDIATE CAUSE (Finel disesse or condition	Dila	led Co	rouion	nu opalk							
	disesse or condition peaulting in death)  Di lated Coronio my opaths  Due to (or as a consequence of):									-		
z	W. 100 P. 100 P.	a HIM	) .									
5	Sequentielly list conditions, if sny, leading to immediate	DUE TO (	OR AS A CONSE	EOUENCE OF	):						-	
S	cause, Enter UNDERLYING CAUSE (Disease or injury	CAI	>									
II.	that initiated events	DUE TO (	OR AS A CONSE	EOUENCE OF	):							
己	resulting in death) LAST	d										
ERTI		e contributing to	leeth but not	reculting in	n the unde	rivino	ceuse alven in	Part I.	24s, WAS AN	MITOPSY	246	WERE AUTOPSY FINDIN
L CERTIFICATION	PART II. Other algolificant condition					8	,		PERFORI	MED?		MAILABLE PRIOR TO COMPLETION OF CAUSE
	PART II. Other algnificent condition											OF DEATH?
	PART II. Other algorificant condition							_	1 _ YES 2	NO NO		
MEDICAL									1 🗆 YES 2	₩ NO		YES 2 NO
MEDICAL	SIAD H						ACE OF DEATH (C)	neck only o		₽ NO		YES 2 NO
MEDICAL	SIADH,	HOSPITAL:			OTHER:	26. PL.	ACE OF DEATH (Ch		ne)	₩O		YES 2 NO
MEDICAL	SIAD H ,	HOSPITAL: 1 Sinpatient 2 □ 260. DATE OF I	ER/Outpatient	3 DOA	OTHER: 4   Nursing	26. PL. Home	s 5 Residence	6 🗆 Oth	ne)			I YES 2 NO
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending	HOSPITAL:	ER/Outpatient	3 🗆 DOA	OTHER: 4   Nursing E OF   26	26. PL.  Homo	s 5 Residence	6 🗆 Oth	ne) er (Specify)			I YES 2 NO
BY PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMPLER?  1  YES 2  NO  27. MANNER OF DEATH  1 Netural 5  Pending Investigation	HOSPITAL: 1 Propertient 2   26e. DATE OF I (Month, De)  28e. PLACE OF	ER/Outpatient NJURY , Year) INJURY — At h	3 ☐ DOA	OTHER: 4   Numing E OF 26 JRY M	26. PL. g Home	o 5 Residence URY AT RK7 'ES 2 NO	6 Oth 28d. DE 261. LO	er (Specify) SCRIBE HOW IN	JURY OC	CURED	
ED BY PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMMER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	HOSPITAL: 1 Propertient 2   26e. DATE OF I (Month, De)  28e. PLACE OF	ER/Outpatient NJURY (, Year)	3 ☐ DOA	OTHER: 4   Numing E OF 28	26. PL. g Home	o 5 Residence URY AT RK7 'ES 2 NO	6 Oth 28d. DE 261. LO	ne) er (Specify) SCRIBE HOW IN	JURY OC	CURED	
ED BY PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined	HOSPITAL:  1 Propertient 2   26e. DATE OF 1 (Month, Dat)  28e. PLACE OF building, e	ER/Outpatient NJURY , Vear) INJURY — At h tc. (Specify)	3 DOA 28b. TIME INJU	OTHER: 4   Nursing E OF 26 JRY M	26. PL.  g Home c. INJU WOI I Y	e 5 Residence URY AT RK7 /ES 2 NO	6 Oth 28d. DE 28d. LO	or (Specify)  SCRIBE HOW IN  CATION (Street at or Town, Stete)	JURY Oct	OVRED or Rural Ro	
ED BY PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2  NO  27. MANNER OF DEATH  1  Netural 5  Pending Investigation  3  Suicide 6  Could not be determined  29e. CERTIFIER (Check only)	HOSPITAL:  1 Impatient 2 Impat	ER/Outpatient NJURY , Year) INJURY — At h tc. (Specify) ny knowledge, d	3 DOA 28b. TIME INJU ome, farm, st	OTHER: 4   Nursing E OF 28 PRY M Itreet, factory	26. PL. g Home c. INJU WOI I Y , office	e 5 Residence URY AT RK7 FES 2 NO end place, end due	6 Oth 28d. DE 28d. LO	er (Specify)  SCRIBE HOW IN  CATION (Street at or Town, Stete)	JURY Occ	or Aural Ro	ute Number,
COMPLETED BY PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMMER?  1  YES 2  NO  27. MANNER OF DEATH  1  Netural 5  Pending 2  Accident Investigation 3  Suicide 6  Could not be determined  29e. CERTIFIER 1  CERTIFYING PHYSI One) 2  MEDICAL EXAMINE	HOSPITAL: 1 Impettent 2 Impett	ER/Outpatient NJURY , Year) INJURY — At h tc. (Specify) ny knowledge, d	3 DOA 28b. TIME INJU ome, farm, st	OTHER: 4   Nursing E OF 28 PRY M Itreet, factory	26. PL. g Home c. INJU WOI I Y , office	e 5 Residence UNY AT RKY (ES 2 NO end place, end due seth occured et the	6 Oth 28d. DE 28t. LOi City to the ca	er (Specify)  SCRIBE HOW IN  CATION (Street at or Town, Stete)	JURY Oct	or Rural Ro	ute Number, end menner as stated.
ED BY PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2  NO  27. MANNER OF DEATH  1  Netural 5  Pending Investigation  3  Suicide 6  Could not be determined  29e. CERTIFIER (Check only)	HOSPITAL: 1 Impettent 2 Impett	ER/Outpatient NJURY , Year) INJURY — At h tc. (Specify) ny knowledge, d	3 DOA 28b. TIME INJU ome, farm, st	OTHER: 4   Nursing E OF 28 PRY M Itreet, factory	26. PL. g Home c. INJU WOI I Y , office	e 5 Residence URY AT RK7 FES 2 NO end place, end due	6 Oth 28d. DE 28t. LOi City to the ca	er (Specify)  SCRIBE HOW IN  CATION (Street at or Town, Stete)	JURY Occurred Number on state I due to the 29d, DAT	or Rural Ro	ute Number, end menner es steted Month, Day, Year)

FINE DAMAGEN HONDER



APR 08 1993



WALCZAK

CERTIFICATE OF DEATH

IF UNDER 1 YEAR | IF UNDER 24 MRS.

6. AGE (In yrs. last birthday)

1 - FOR STATE REGISTRAR

1. OECEDENT'S NAME (First, Middle, Last)

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BALTIMORE, MARYLAND 21215-0020	\$	4
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P.O. BOX 68/60,	th certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician.	andian physician and completely filled in his the femoral diseases were E about the described for the territories
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7. DATE OF BIRTH (Month, Day, Year, 1-7-28 1 M 2 F DAYS HOURS 65 YRS. 98. FACILITY NAME (If not institution, give street and number) Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR BALTIMORE CITY CHURCH HOSPITAL CORPORATION RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION MARYLAND BALTIMORE 100. STREET AN Robinson FUNERAL 10f. ZIP CODE 706 S. POTOMAS STREET 21224 11 MADITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuben, Maxican, Puerto Rican, etc.)
1 YES 2 NO Specify: 1 💢 Never Married 2 🗌 Married BY 3 Widowed 4 Divorced COMPLETED 15. OECEDENT'S EDUCATION (Specify only highest grade completed) 18e. DECEDENT'S USUAL OCCUPATION most of working Elementary/Secondary (0-12) 12 YEARS College (1-4 or 5+) HOMEMAKER Once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Malden Surname) JOSEPH WALCZAK notified at JOSEPHINE SCHULTZ 19a. INFORMANT'S NAME (Type/Print) 196. MAILING AD. Robinson MR. DANIEL WALCZAK 706 S. POTOMAE ST. BALTO. MD. 21224 pe 204\_METHOD OF DISPOSITION
1 Charles 2 Cremetion 3 C Rem 20b. PLACE AND DATE OF OISPOSITION (Name of must HULY RUSARY CEM. 4 Donation 5 Other (Specify) the medical examiner 21/RIGNATIONS OF FUNERAL BETWICE LICENSEE KACZOROWSKI FUNERAL HOME 2525 FLEET ST. BALTO. MD. 21224 pretery miled in by the cremation, or removal. 23. PART I. Enter the diseases, or complications that ceused the deeth. Do not anter the mode of dying, such as cardiac or reapiratory arrest, affock, or heert failure. List only one cause on each line. IMMEDIATE CAUSE (Final HBART PAKUNG disease or condition event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF) to burial, traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST 6 signed by the atter Health and Mental PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. . DR ATTENDING PHYSICIAN: The law requires that the DIRECTOR: After this certificate has been signed by the hours after death with the State Dept. of Health and Me Hem 28 is marked, or Item 23 shows any Inju MEDICAL PAILVRE PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) EXAMINER? HOSPITAL:

| Minpetient 2 | ER/Outpatient 3 | DOA | 4 | Nursing Name 5 | Residence 6 | Other (Specify) 27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DEȘCRIBE NOW INJURY OCCURED 1 R Natural 5 Pending Investigation BY 1 YES 2 NO 2 Accident 3 Sulcide 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined COMPLETED 4 Nomicide 29s. CERTIFIER (Check only one)

One)

APPICAL EXAMPLE: On the best of my knowledge, death occurred at the time, date and piece, and due to the cause(e) and menner ee stated. THE HOSPITAL D THE FUNERAL D RIOD WITHIN 72 PK 2 MEDICAL EXAMINER: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 017322 asemi 2 2 3 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (TEM 27) (Fig. Print) BROADWAY STREET, BALTIMORE MD 21231

AL RESISTRAR'S SIGNALIFIE OF

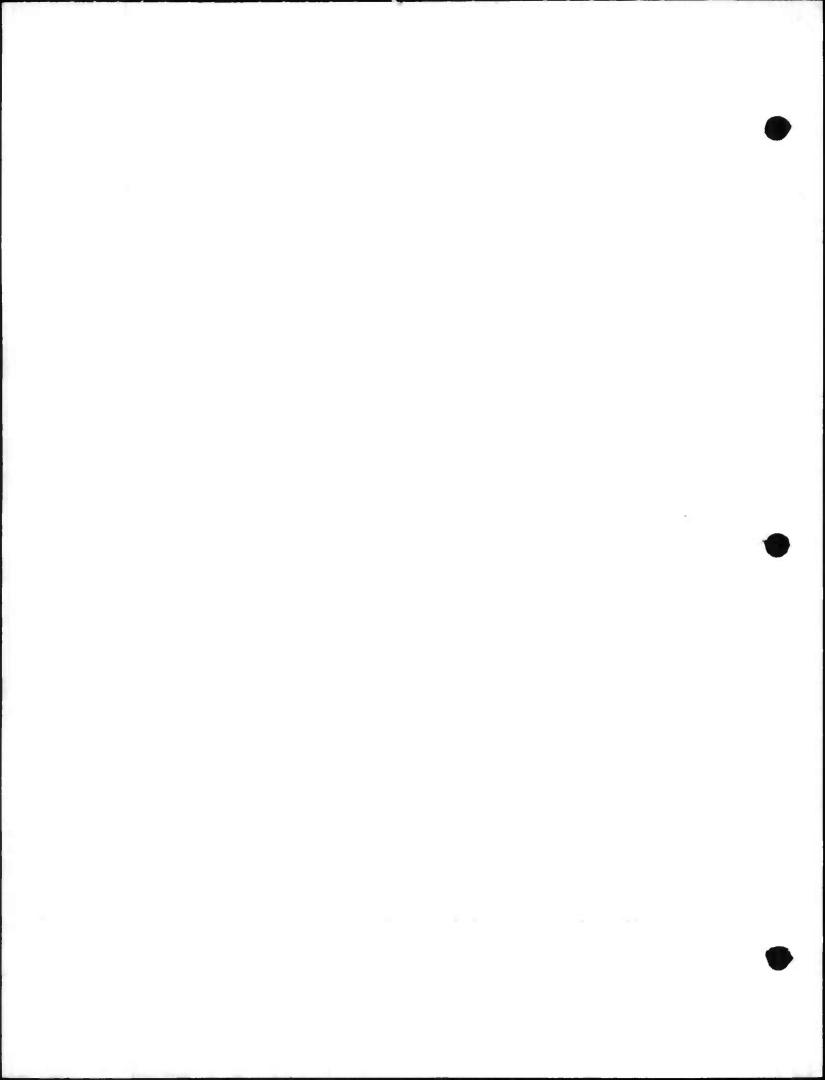
93 09939 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 2. DATE OF DEATH MONTH 6 DAY 3. TIME OF OEATH 12:45AM MARYLAND 9c. COUNTY OF DEATH 10d. INSIDE CITY 1 YES 2 NO 10g, CITIZEN OF WHAT COUNTRY? USA 14. RACE — American Indian, Black, White, etc. Specify WHITE 16b. KIND OF BUSINESS/INDUSTRY "yte Number, City or Town, State, Zio Code) OATE 20c. LOCATION — City or Town, Stata 4-12 BALTO. CO. MD. Approximata Interval Betwee Onset and Death evas 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 NO OF DEATH? 1 | YES 2 | NO 28f. LOCATION (Street and Number or Rural Floute Number, City or Town, State)

31. DATE FILED (Month, Day, Year)
APR 08 1993

DIVISION OF VITAL RECORDS,

29d. DATE SIGNEO (Month, Day, Year)

V416193



DIRECTOR

FUNERAL

BY

COMPLETED

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CERTIFICATION

MEDICAL

PHYSICIAN:

BY

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APR 08 1993

32. AUGISTRAR'S MENATURE

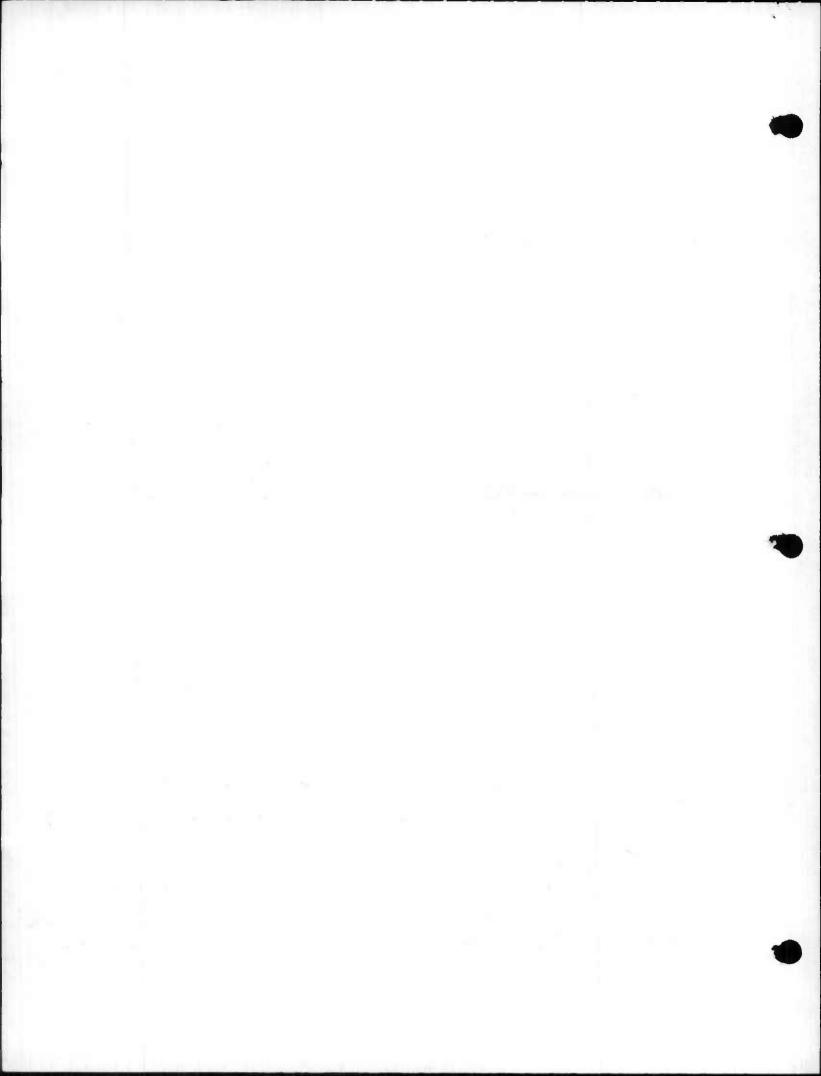
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the part of the death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR; After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages	be filed within 72 hours man seath with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: I maked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
R ATTENDING PHYSICIAN: The law requires that the	RECTOR: After this certificate has been signed by ti	us after death with the State Dept. of Health and I	in 28 is marked, or item 23 shows any in
TO THE HOSPITAL D	TO THE FUNERAL DI	be filed within 72 ha	IMPORTANT: # 11

09940 FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 6/93<sub>YEAR</sub> 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 9:06A THOMAS P. WHELLEY, JR. 7. DATE OF BIRTH (Month, Day, Year 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign MONTHS DAYS HOURS 075-01-9516 1XXM 2 ☐ F 80 OCT.16,1912 NEW YORK 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH BALTIMORE 1104 HARWALL ROAD WOODLAWN RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a. STATE 10d. INSIDE CITY MARYLAND BALTIMORE WOODLAWN 1 TES 2 XXNO 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 101, ZIP CODE 1104 HARWALL ROAD 21207 U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yea, specify Cuben, Maxican, Puerto Rican, etc.)
1 YES 2 XXO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1X YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married
3 Wildowed 4 Divorced Specify WW II WHITE 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b, KIND OF BUSINESS/INDUSTRY U.S. ARMY CORP OF Elementary/Secondary (0-12) ENGINEERS 4 ENGINEER 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) THOMAS P. WHELLEY **VERA** LALLY 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 6512 APPLE BLOSSOM RIDE, COLUMBIA, MARYLAND 21044 DENNIS WHELLEY (SON) 20e. METHOD OF DISPOSITION
1 ☐ Burlet XX Cremetion 3 ☐ Removal from State
4 ☐ Donation 8 ☐ Other (Specify) \_\_\_\_\_ 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 20c. LOCATION - City or Town, State METRO CREMATORY CATONSVILLE, MARYLAND 4/7/93 21, SIGNATURE OF FUNDRAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1 insella 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Approximata** shock, or heart feliure. List only one cause on each line. Interval Between Onset end Death IMMEDIATE CAUSE (Final TI INFLICTED WRIST LACORATION

PUE TO (OR AS A CONSEQUENCE OF): disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to dayth but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS 24s. WAS AN AUTOPSY AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? ARCINOMO 1 TYES 2 FATO 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMPLER? OTHER: 1 Donation 2 ER/Outpetient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28a, DATE OF INJURY 28b. TIME OF 28d, DESCRIBE HOW INJURY OCCURED Day Year) 1 Natural 5 Pending М 1 YES 2 110 2 Aggldent 3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Nu City or Town, State) 6 Could not be 4 Homicide 04 ome 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner (Check only one) DICAL EXAMINER: On the basis of examin on and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and menr 29b. SIGNAT 29¢ LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year)

DHMH-18 Rev 1/89

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BALTIMORE, MARYLAN

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

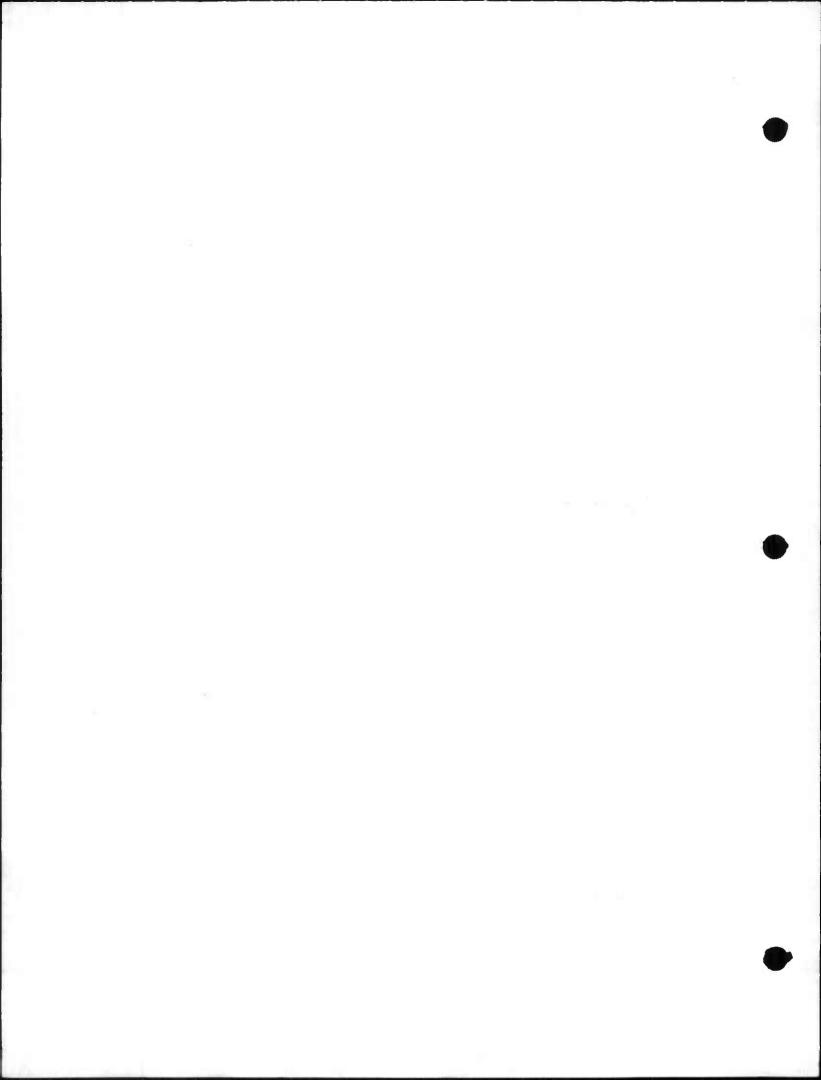
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מוני מוני מוני מוני מוני מוני מוני מוני		8 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
200	ter death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	nedical
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31. DATE FILED (Month, Day, 1993)

	FOR	STATE OF MADVI	AND / OFDAT	THENT OF I	1541711 441D :		9	3	099	18 [
	1 - STATE REGISTRAR	STATE OF MARYL	CERTIF	ICATE OF	DEATH	MENTAL HYGIEN REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3.	TIME OF DEA	ТН
	Laura R. Whit	e				MONTH 4/6/		AR	1:00	Рм
	4. SOCIAL SECURITY NUMBER 212-40-7677	5. SEX 6. AGE (	In yrs. leaf birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	1.1	BIRTHPL Country)	ACE (State or F	oreign
~	9a. FACILITY NAME (If not institution, give 1444 Hull Str	street and number)			OR LOCATION OF DE	EATN	9c. COUNTY	OF DEAT		
0	RESIDENCE OF DECEDENT	eet		BALLI	MORE CI	TY				
EC	10a. STATE 10b. COUNT	Υ	10c. CIT	TY, TOWN OR LOCAT	TION			10	d. INSIDE CIT	
L DIRECTOR	MD  10e. STREET AND NUMBER		В	altimor				12	LIMITS?	
FUNERAL	1444 Hull Str	eet		101	ZIP CODE	1230		OF WHA	A .	
5	11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES		13. WAS DEC	ENDENT OF NISPAN	IIC ORIGIN? (Specify Yen, Puerto Rican, atc.)	s or No — 14.	RACE -	American Indi	lan,
BY	XX Widowed 4 □ Divorced	IF YES, GIVE WAR OR DA			2 X No Specify			Specify:	WHIT	E
Ë	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	(Give kind of	USUAL OCCUPATION	ON st of working	16b. KIND OF BU	SINESS/INDUST	RY		
COMPLETED	Elementary/Secondary (0-12) 6th Grade	College (1-4 or 5 +)	Home	emaker						
SO.	17. FATHER'S NAME (First, Middle, Last)		HOM	CHICKCI	18. MOTNER'S NAI	ME (First, Middle, Maiden	Surname)			
BE C	JOSEPH GOLEB	IEWSKI				IE KORES		ΚI		
2	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Tow				
_	ELMER BRUCE 200. METNOD OF DISPOSITION					Baltimo			21230	
	XIXBuriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State 20b.	etery, crematory or o	of disposition (Na other place) DSS Cem	me of eteru	4/101	CATION — City			
	21. SIGNATURE OF FUNERAL SERVICE		017 010	22. NAME AN	D ADDRESS OF FAC	CILITY	altimor			
	- a Mus	ei Do	2	1501 E	E. Fort A	vens Funer venue, Bal	Ltimore	. MI	nc. 2123	30
	23. PART I. Enter the diseasea, pre- ehock, pr heert fellure.	complications that caused	the death. Do r	not enter the mo	de of dying, suct	n as cerdlec or reap	iratory arreat,		Approxim interval B	
	IMMEDIATE CAUSE (Finel disease or condition	M	1 1.1		44	1. 1.	1	٠	Onset and	
	resulting in death)	a. DUE TO (OR AS A	CONSEQUENCE OF	20515		wom hoc	YTORO	ud	6 h	104.
z		h.		. ,.					ĺ	
ET I	Sequentielly list conditione, If any, landing to immediate  DUE TO (OR AS A CONSEQUENCE OF):									
FICA	CAUSE (Disease or injury	C. DUE TO (OR AS A	CONSEQUENCE OF	P.						
CERTIFICATION	that initieted eventa reaulting in death) LAST	4	ONOLOGINOL O	.,						
	PART II. Other elevisions annulated	O								
PHYSICIAN: MEDICAL	PART II. Other algnificent condition	ia contributing to death be	ut not resulting i	in the underlying	g couse given in i	Part I. 24s. WAS AN PERFOR		AM	RE AUTOPSY F	TO
						1 YES	NO		MPLETION OF O	CAUSE
2								1 [	☐ YES 2 ☐ I	NO
ZA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			28. PL	ACE OF DEATN (Che	ick only one)				
YSI	1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Output	atlent 3 DOA	OTHER: 4   Nursing Nome	Reeldence	a Other (Specify)				
- 1	1 Natural 5 Pending	28s. DATE OF INJURY (Month, Day, Year)	28b. TIM	URY WO	URY AT RK?	28d. DESCRIBE NOW I	NJURY OCCURE	D		
BY	2 Accident Investigation 3 Suicide a Could not be	28e. PLACE OF INJURY	— At home, farm, s			28I. LOCATION (Street :	and Number or Ri	ural Route	Number.	
ETED	4 Nomicide datermined	building, etc. (Speci	ify)			City or Yown, State)				
COMPL		CIAN: To the best of my knowle						ise(a) an	d menner aa s	tated,
BE C	29b. SIGNATURE AND TITLE OF CONTIFIES		40		29c. LICENSE NUM		29d. DATE SIG			>
2	30. NAME AND ADDRESS OF PERSON WILL	OCOMPLETED CAUSE OF DEA	TN (ITEM 27) (Type,	Print)	1	0 20 5		3	7	2
	Ur Ian	> haut 2	4191	1/0	unta	n Rd,	1959	de	ana b	(d.

1 - STATE 4/16/93 rebSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

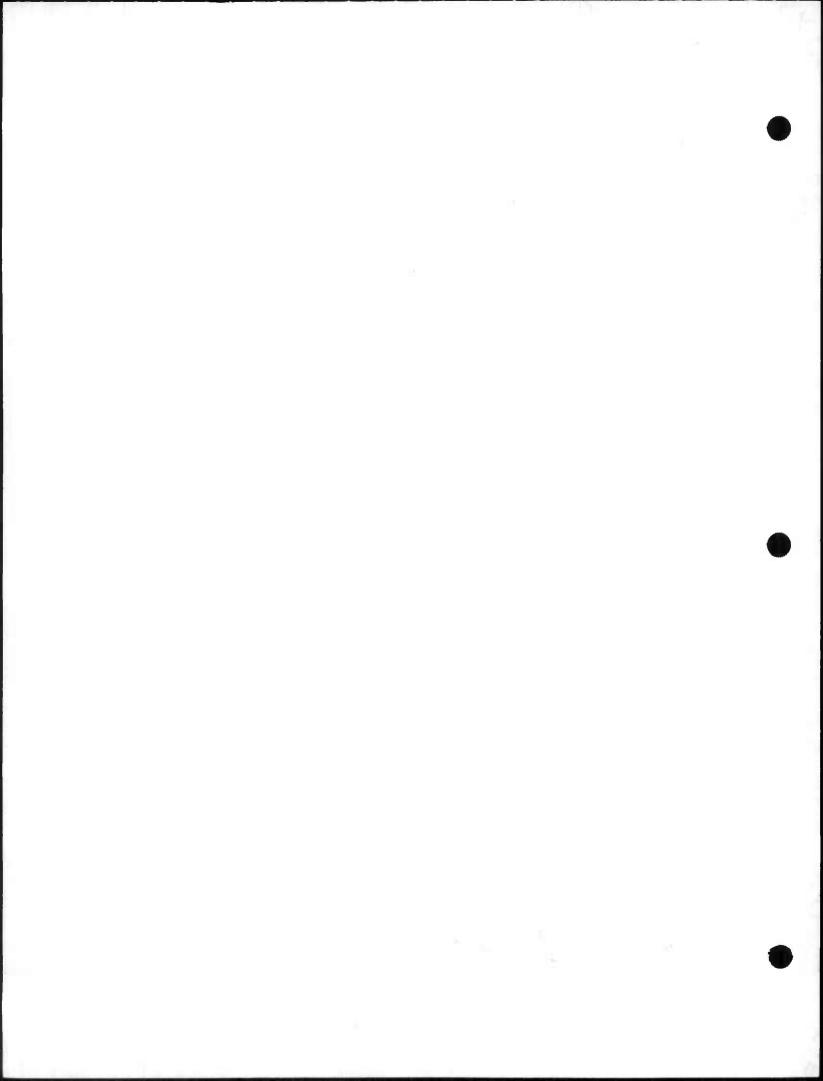
			NEGISTRAN		CI	ENTIF	CALE	FUEAIR		REG. NO.			
			1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATH			. TIME OF OEATH
			BETTY	J.		W	VALTER	?	03	30 🖱	1993	TEAR	11:15 Am
			4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	st birthday)	IF UNDER 1 YEAR	R IF UNDER 24 HRS.	7. DATE OF	BIRTH		B. BIRTHPL	ACE (State or Foreign
				1 🗆 M 2 🖵 F	45	YRS.	MONTHS DAYS	B HOURS MIN.	(Month, E			Country)	
	pinods		9e. FACILITY NAME (If not institution, give s	- 41	43		Oh CITY TOWN	N OR LOCATION OF D		5-1947			
	Sh Sh	Œ		out and named,		- 1			EAIN		- A- 1	TY OF DEA	
	cí i	СТОВ	706 SMITH ST.				SALIS	BURY			MIC	OMIC	20
		ည္မ	10e. STATE 10b. COUNTY			10c. CITY	TOWN OR LOC	CATION					0d. INSIDE CITY
	Pages	DIRE	May 1 2										LIMITS?
	permit.		Maryland Wi	comico (	Co	J S	alisbu:						YES 2 NO
		FUNERAL					1	10f. ZIP COOE			10g. CITIZ	EN OF WH	AT COUNTRY?
9	burial-transit	9	706 Smith Stree	t									
020 obseiciae	rial-t	5	11. MARITAL STATUS		T EVER IN U.S. AR		13. WAS D	ECENDENT OF HISPA specify Cuben, Mexic	NIC ORIGIN?	Specify Yes	or No-	I4. RACE -	- American Indian, White, etc.
) 0 1 1		BY	1 Never Married 2 Merried 3 Wildowed 4 Divorced		MAR OR DATES			ES 2 NO Specif		an, 610.7		Specify:	eder to
215-0	as th												White
2		뎶	15. DECEOENT'S EDUC (Specify only highest grade		(G	ive kind of wo	USUAL OCCUPA ork done during		16b, K	IND OF BUS	INESS/INDU	STRY	
2 2	5 -		Elementary/Secondary (0-12)	College (1-4 or 5	Who	. Do NOT use	retired.)						
	detached for	A P											
LAND 2		COMPL	17. FATNER'S NAME (First, Middle, Last)					18. MOTNER'S NA	AME (First, Mid	dle, Maiden S	Surname)		
7	1 m	BE											
MARYLAND 21215-0020 retained by the bosoital or attending objects	5 should notified		19+. INFORMANT'S NAME (Type/Print)		191	b. MAILING	AODRESS (Street	et end Number or Rural	Route Number,	City or Town	, State, Zip (	Code)	
Σ	- v2	2	ocme										
RE, E	page 1		20e. METHOD OF DISPOSITION		20b. PLACE	ANDDATEO	F DISPOSITION /	(Neme of	OATE	20c. LOC	CATION — C	ty or Town	. State
OF	nus nus		1 Buriel 2 Cremation 3 Remarks 4 Donation 5 Other (Specify)	oval from State	cometeny cre			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				., ., .,	, 0.1110
BALTIMORE, after death. Page 6 may be by the funeral director, page moval. cal examiner must be			21, SIGNATURE OF FUNERAL SERVICE US	ENSEE 4	enovar	D.L.	22 NAME	AND ADORESS OF FA	CILITY O				
<b>5</b> £	mera mera		Strong 111	ROBAL	d wade,	Dir			56	ate A			
A S		_	Millia 1 li	1404	4/7	/93	655	W,Baltimo	re St,	Balto	o,MD	21201	
- after	5 = 1	-/	23. FART I. Entar the diseases, or o	omplicatione tha	it caused the de	ath. Do no	ot entar the n	node of dying, suc	h as cerdie	c or reapir	retory arre	st,	Approximate
Popular	.= . •		anock, or naart failure.	Liet only one ceu	use on each line								Interval Between Onset and Death
24	y filled tion, or	- 1	IMMEDIATE CAUSE (Finel disease or condition	THIO		E 7 41	T O V T O	A T T O AL					Onset and Death
60,	ompletely fill I, cremation, event, the		resulting in death)		OR AS A CONSE			AIIUN			-		
76 176	5 m	_ 4		552 10	(ON AS A CONSE	DUENCE OF	).						
C 68760, executed within	sician and com infor to burial, c traumatic ev	RTIFICATION	Sequentially list conditions,	OUE TO	(OR AS A CONSE	NIENCE OE	A.						
O 3	or to	F	if any, leading to immediate cause. Enter UNDERLYING										
O. BO	6 6	윤	CAUSE (Disease or Injury C.										
	nding phy Hygiene p or other	Ē	that initiated events resulting in death) LAST										
O (	S - 0	S		1									-
RDS,	y the att od Menta injury,		PART II. Other aignificant condition	contributing to	deeth but not r	eaulting in	tha underly	ing ceuse given in	Part I. 2	ta. WAS AN /	AUTOPSY	24b. W	ERE AUTOPSY FINDINGS
DRI That I	20	DICAL						ing. — in government		PERFOR		Al	WAILABLE PRIOR TO OMPLETION OF CAUSE
	signed Health a								- 1	YES 2	□ NO		F DEATH?
A Per	of H	Σ							_			1	YES 2 NO
	has been Dept. of h	SICIAN:											
VISION OF VITAL. ATTENDING PHYSICIAN: The law	State D	5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			28. OTHER:	PLACE OF OEATN (C)	neck only one)				
<b>&gt;</b> ₹	rtifica he Str	S	ÿÇXYES 2 □ NO		ER/Outpatient 3			ome 5 KResidence	8 Other (S	Specify)			
2 5 5 5 5 5	S Cer	РНҮ	27. MANNER OF DEATH	28e. DATE OF	INJURY	28b. TIME		NJURY AT WORK?	28d. DESCF	NBE HOW IN	JURY OCCU	IRED	
2 2	fter this ceath with marked,	BY	1 Natural 5 Pending 2 Accident Investigation	F dent E	30/93	UNK		YES X X NO	HNK	NOWN			
OR ATTENDING	After death		3 Suicide 6 Could not be	28e. PLACE C	F INJURY - At ho		reet, factory, of	fice	28f. LOCATI	ON (Street as	nd Number o	r Rural Rou	te Number,
2 8	DIRECTOR: After hours after death tem 28 is ma	ш	4 Nomicide determined	10-501	etc. (Specify)					Town, Stete)	706		TH ST.
- 6	E 3 2	Щ	29e. CERTIFIER	HOME						SBUR			
A L	AZ H	₹ I	(Check only one)										
OSP	TO THE FUNERAL D be filed within 72 ho IMPORTANT: It Is	COMPLET	2 MEDICAL EXAMINE	n. Un the basis of s	xamination end/or i	Investigation	, in my opinion	, death occured at the	time, date an	d place, end	due to the	ceuse(e) e	nd manner ee stated.
Ä	PR W	BE	29b. SIGNATURE AND TITLE OF CERTIFIED	1 .	VI (77509-126			29c. LICENSE NU	MBER		29d. DATE	SIGNEO (M	fonth, Day, Year)
0	E 8 €		Nonald Hill	Mahr	- MD			0.C.N	1. F.		DO3.	-31-	1993
_		2	30. NAME AND ADDRESS OF PERSON WH	COMPLETED CAU									
			DONALD G WRIGHT					treet, I	Balti	more	, Ma	ryla	ind 2120
	j		31. DATE FILED (Month, Day, Year)	-	AR'S SIGNATURE							_	
			APR - 8 1993		in finder								
		10		1	4		-						



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

al or attending physician.	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should		
FITTOLICIAN. THE IMPRINGS THAT THE DESIGN CELTIFICATE DE EXECUTEU WHITH ZA NOUTS ATTER DEATH. PAGE D MAY DE RETAINED BY THE NOSPITAL OF ARENDING BY	tor, page 5 should be detached		oust be notified at once.
III 24 nours after beath. Fage	ally filled in by the funeral direc	lation, or removal.	ed, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once
certificate be executed with	ding physician and complete	ith the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	r other traumatic event,
Idea reduites that the ceath	has been signed by the atten-	Dept. of Health and Mental I-	23 shows any injury, or
ALIENDING PHISICIAIN. LITE	STOR: After this certificate h	ter death	28 is marked, or item
IN THE HUSELIAL ON A	MUTHE FUNERAL DIREC	* The within 72 hours af	IMPORTANT: If Item
	# W	ωń	

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND /	DEPARTMENT OF ERTIFICATE OF	HEALTH AND M	ENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)  Wordell T.	Wheatle	U		2. DATE OF DEATH	3 93	3. TIME OF PEATH
	0.0	6. AGE (In yrs. las	YRS. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Morth, Day, Year)	8. BIR	THPLACE (State or Foreign nitry)
TOR	9a. FACILITY NAME (If not institution, give street  Stella Maris  RESIDENCE OF DECEDENT	Hospice	-	OR LOCATION OF DEAT		BOULD BOULD	MORE
DIRECTOR	10a. STATE 10b. COUNTY		Balto	ATION			10d. INSIDE CITY LIMITS?  1 N YES 2 NO
FUNERAL	100. STREET AND NUMBER 4736 Wren	wood Ave		01. ZIP CODE 2/2/2		10g. CITIZEN OF	WHAT COUNTRY?
BY FUN	11. MARITAL STATUS  1 Never Married 2 Married  3 Widowed 4 Divorced	2. WAS DECEGENT EVER IN U.S. AR FORCES? 1 YES 2 YI IF YES, GIVE WAR OR DATES	NO If yes, s	CENDENT OF HISPANIC pecify Cuben, Mexican, S 2 O'NO Specify:		Bla	CE - American Indian, ick, White, etc.
COMPLETED		mpleted) (G	CEDENT'S USUAL OCCUPATIVE kind of work done during in Do NOT use retired.)		16b. KIND OF BUS	I BINESS/INDUSTRY	
	17. FATHER'S NAME (First, Middle, Lest)		uchouse M	18. MOTHER'S NAME	(First, Middle, Maiden	Surname)	
TO BE	190. INFORMANT'S NAME (Type/Print)	attey 191	b. MAILING ADDRESS (Street	and Number or Rural Rou	te Number, City or Town	n, State, Zip Code)	1 2000
	20a. METHOD OF DISPOSITION  1√ Burlel 2 □ Cremation 3 □ Remove  4 □ Donation 5 □ Other (Specify)	of from State	AND DATE OF DISPOSITION (National or of other place)	lame of	0ATE 20c. LO	cation - city or a 1 to . 1	Yd 21212 Town, State
	21. SIGNATURE OF FURITRAL SERVICE LICEN	SEE Mass	lan ene	THE PROPERTY OF FACIL		4	he 2/2/5
	23. PART I. Enter the diseases, or corehock, or heart fellure. Lis immediate CAUSE (Final disease or condition resulting in deeth)	nplications that caused the de to only one cause on each line	f Lung	ode of dylng, such s	ss cerdiec or respi	ratory errest,	Approximate interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSECUENT OUE TO (OR AS A CONSECUENT)	•				
PHYSICIAN: MEDICAL C	PART II. Other significant conditions	contributing to deeth but not r	eeuiting in the underlyli	ng ceuse given in Pa	ert I. 24a. WAS AN PERFOR 1 TYES 2	MEO?	Ib. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
CIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IOSPITAL:	26. F	LACE OF DEATH (Check	only one)		
PHYSI		☐ Inpatient 2 ☐ throughament / a  26e. DATE OF (NJURY (Month, Day, Year)	DOA 4 Nursing Hot 28b. TIME OF 28c. IN INJURY W	ORK?	8d. OEŞCRIBE HOW II	HODICE HURY OCCUREO	
ED BY	2 Accident 3 Suicide 6 Could not be determined	26e. PLACE OF INJURY — At hos building, etc. (Special)		YES 2 NO	61. LOCATION (Street a City or Town, State)	nd Number or Rura	Floute Number,
COMPLETED		N: To the best of my innervence der					(a) and manner so stellar
8	29b. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NUMBE D 15504		29d. DATE SIGNE	D (Month, Day, Year)
5	E. Nakhuda M.D.,	2300 Dulaney V	allev Road.	Towson. M	d 21204		
	31. MAPR 108: 1993 g	AL REGISTRAR'S SIGNATURE	2		<u> </u>		



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. o. 31-31-93 GEBENT'S NAME (First, Middle, Last WHALAND 2. DATE OF DEATH 3. TIME OF DEATH 8:06 IF UNDER 1 YEAR IF UNDER 24 HRS DAYS HOUNE I DAZ DE Pages 1, 2, 3 should 86. CITY, TOWN OR LOCATION OF D Sc. COUNTY OF DEATH DIRECTOR Harbor Hospital Baltimore NA 10s. STATE 10s. CITY, TOWN OR LOCATION 10d. INSIDE CITY BALTIMORE CITY 1 YES 2 NO permit FUNERAL 104. STREET AND NUMBER IN. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21230 OSTEND ST E detached for use as the burial-transit nours after death. Page 6 may be retained by the hospital or attending physician. 13. WAS DECEMBENT OF HISPANIC ORBGINT (Specify Yes or No-If yes, specify Cuben, Maxicon, Puerte Ricen, etc.) 1 YES 2 MO Specify-II. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. Never Married 2 [ Married FORCEST 1 YES 2 NO IF YES, GIVE WAR OR DATES BY White 3 Wildowed 4 C Olverted COMPLETED 15. DECEDENT'S EDUCATION HOly only highest grade complete 16s. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working the Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) once. 17, PATHER'S NAME (First, Mickly, Lant) 18. MOTHER'S NAME (First, Middle, Maiden Surname) funeral director, page 5 should be W BE notified 16s. INFORMANT'S NAME (Type:Print) 19b. MAILING ADDRESS (Street and Number or Plurel Route Number, City or Town, State, Zip Code) 2 Z 20a. METHOD OF DISPOSITION
1 □ Burlat 2 □ Cremation 3 □ Re 30b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State Ħ 4 Donatigo T Dotter (Specify) in state MERAL SERVICE MCEASE RODALD Wade, Dir examiner SIGNATURE OF SE 22. NAME AND ADDRESS OF FACILITY StateAnatomyBoard 4/7/93 655W.BaltimoreSt,Balto,MD 21201 signed by the attending physician and completely illied in by the Health and Mental Hygiene prior to burist, cremation, or removal. medical 23. PART I. Enter the dise ses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death 畫 executed within event. resulting in death) ing disase traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate PHYSICIAN: The law regulnes that the death certificate be cause. Enter UNDERLYING CAUSE (Disease or Injury other that initiated events resulting in death) LAST ò Injury. PART II. Other significant conditions contributing to death but not resulting MEDICAL 24s. WAS AN AUTOPSY 24h, WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE amy TI YES 2 LAND shows a OF DEATHY has been of h I YES 2 NO PHYSICIAN: Item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) h the State I HOSPITAL: OTHER: TO YES 2 DE et 2 - ER/Outpetient 3 - DOA ome 5 - Residence 6 - Other (Specify) 8 36c. INJURY AT WORK! With a marked. 28s. DATE OF INJUSTY (Month, Day, Year) 264. DESCRIBE HOW INJURY OCCURED 1 Natural e hospital, or attending pr e funeral, director, afier 11 1 within 72 hours effer death v rtante, 11 hom 28 is mark 1 VES 2 NO BY Atter death 2 Accident 38e. PLACE OF INJURY -- At home, farm, street, factory, office 3 Swicide 281. LOCATION (Street and Number or Flural Route Number, City or Tawn, State) COMPLETED 6 Could not be 4 | Homicide 29a. CERTIFIER 1 DESTIFYING PHYSICIAN: To the best of my knowledge, death occurrent at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On th TO THE FUNEHA TO THE FUNEHA De filed within 7. digetion, in my opinion, death occured at the time, date and place, and due to the ca 띪 29d. DATE SIGNED (Mogth, Day, War) 9 3 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Julia Deniser Rondolla

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DIRECTOR

COMPLETED BY FUNERAL

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COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BE 2 30

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(Check only one)

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cause. Enter UNDERLYING

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. once. event, the medical examiner must be notified at IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic

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FOR STATE REGISTRAR	STATE OF N	MARYLAN	D / DEPAR CERTIF	TMENT ICATE	OF H	EALTH DEAT	AND I	MENTAL HYGIEN REG. NO				
1. DECEDENT'S NAME (First, Middle, Last	t)							2. DATE OF DEATH			3. TIME OF DEATH	
MILDRED	ELIZABET	H	WRIG	HT				4 0:		993	м	
4. SOCIAL SECURITY NUMBER	1 C M 2/57 E			rs. lest birthday) IF UNDER 1 YEAR  63 YRS. MONTHS DAYS		IF UNDER	24 HRS. MIN.	7. DATE OF BIRTH (Month, Day, Year) 7-17-1929	Q	Count	BALTIMORE, MD.	
Sa. FACILITY NAME (If not institution, give	atreet and number)			9b. CITY, T	OWN OF	R LOCATI	ON OF DE		,	INTY OF D		
1620 W. SARATOO	GA STREET			BALTIMORE CITY BALTIMORE					IMORE			
10a. STATE 10b. COUN	ITY		10c. CIT	Y, TOWN OR	LOCATA	ON .					40.4 Melbe orry	
MD.			100.51				CITY	Z			10d. INSIDE CITY LIMITS? 1 TY YES 2 NO	
10e, STREET AND NUMBER						ZIP CODE			10g. CITIZEN OF WHAT COUNTRY?			
1620 W. SARATOGA			21223 U				JSA.	JSA.				
11. MARITAL STATUS  1 Never Married 2 Married  1 Widowed 4 Nolvorced  12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES				13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.)  1 ☐ YES 2X☐ NO Specify:  BLACK					olfy:			
15. DECEDENT'S ED (Specify only highest grad		16a	DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working			ю	16b. KIND OF BUSINESS/INDUSTRY					
Elementary/Secondary (0-12)	College (1-4 or 5 +	-)	Me. Do NOT use retired.)  DOMESTIC									
17. FATHER'S NAME (First, Middle, Last)						16. MOTE	HER'S NAI	ME (First, Middle, Maiden	Surname)			
CLARENCE MI	ITCHELL				1		ORE					
19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	AOORESS (	Street an			Route Number, City or Tow		D Code)		
ALLEN WRIGHT								ET, BALTIM			21223	
20a. METHOD OF DISPOSITION 1 反 Burlel 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	movel from State	cemetery	CEANDDATE OF COUNTY OF OR OTHER PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF T	ther place)					cation – TIMOI			
21. SIGMATURE OF FUNERAL SERVICE DICENSEE					OSEP 3 W.	BAL'I		OWN JR. FU ST. BALTO.	NERAI	L HON 21223;	ME, P.A. P.O. BOX 4433	
23. PART I. Entar the diseases, or shock, or heert fallure	r complications that b. List only one cau	t caused that se on aach	death. Do r	not entar th	ne mod	a of dyl	ng, suct	as cardiac or reapi	ratory ar	rest,	Approximate Interval Between	
IMMEDIATE CAUSE (Final disease or condition resulting in deeth)	. Or	rario	n 1	Con.	ces	5					Onset and Death	

CAUSE (Disease or Injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24a. WAS AN AUTOPSY PERFORMED? 1 - YES 2 - NO 1 TYES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 YES 2 NO enca 8 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 1 Natural
2 Accident Pending Investigation 1 YES 2 NO 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 3 🗌 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide 29a. CERTIFIER

OUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(e) end manner se stated.

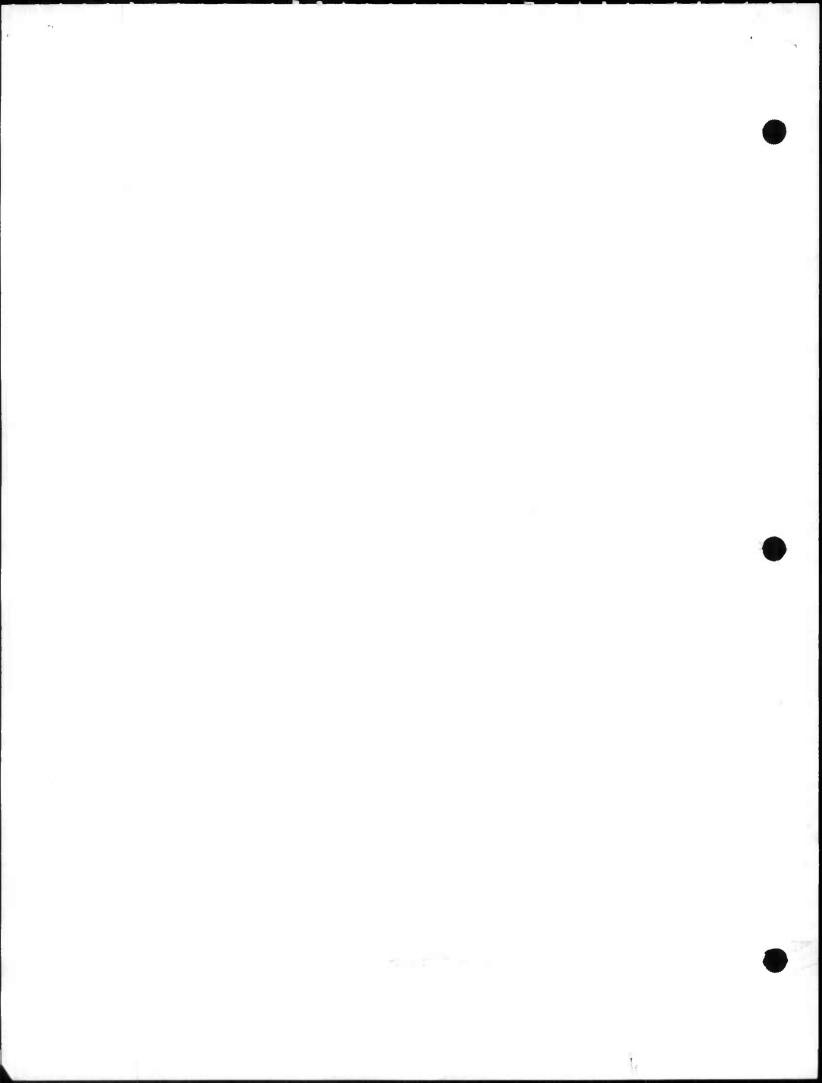
7/	/		nt, many opinion, seems occured at the time, data and place,	and due to the couse(s) and manner as stated
SIGNATURE AND TITLE OF CERTIFIER	77	-1/1	29c. LICENSE NUMBER	29d, DATE SIGNEO (Month, Day, Year)

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296. SIGNATURE AND TITLE OF CERTIFIER	/		1	29c. LICENSE NUMBER	29d. DATE SIGNEO (Month, Day, Year)
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NAME AND ADDRESS OF PERSON	N WHO COMPLETED CAUSE OF CEATH (ITEM 27) (Type, Print	St Agnes Hose	taln 1		T

APR 08 1993 Julia Savidana Barta	William C. Wa,	fer field MD	900 Cata	Acre L	Bull !	n/	2122
	100 100 100c	32 REGISTRAR'S SIGNATURE Suha Davidson Rando 100					

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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

use as the burlaf-transit permit. Pages 1, 2, 3 should the hospital or attending physician. funeral director, page 5 should be detached for once. notified at Page 6 may be retained by 9 must examiner iours after death. n by the furemoval. medical filled in by t 6 completely filler the requires that the death certificate be executed within event. and corr o burial, traumatic prior to been signed by the attending physician it of Health and Mental Hygiene prior to shows any Injury, or other traum Dept. HOSPITAL OR ATTENDING PHYSICIAN: The law this certificate han with the State Durked, or item 2 marked, After 1 90 DIRECTOR: A hours after d TO THE FUNERAL DE filed within 72 h 포프 299

DONALD G. WRIGHT,

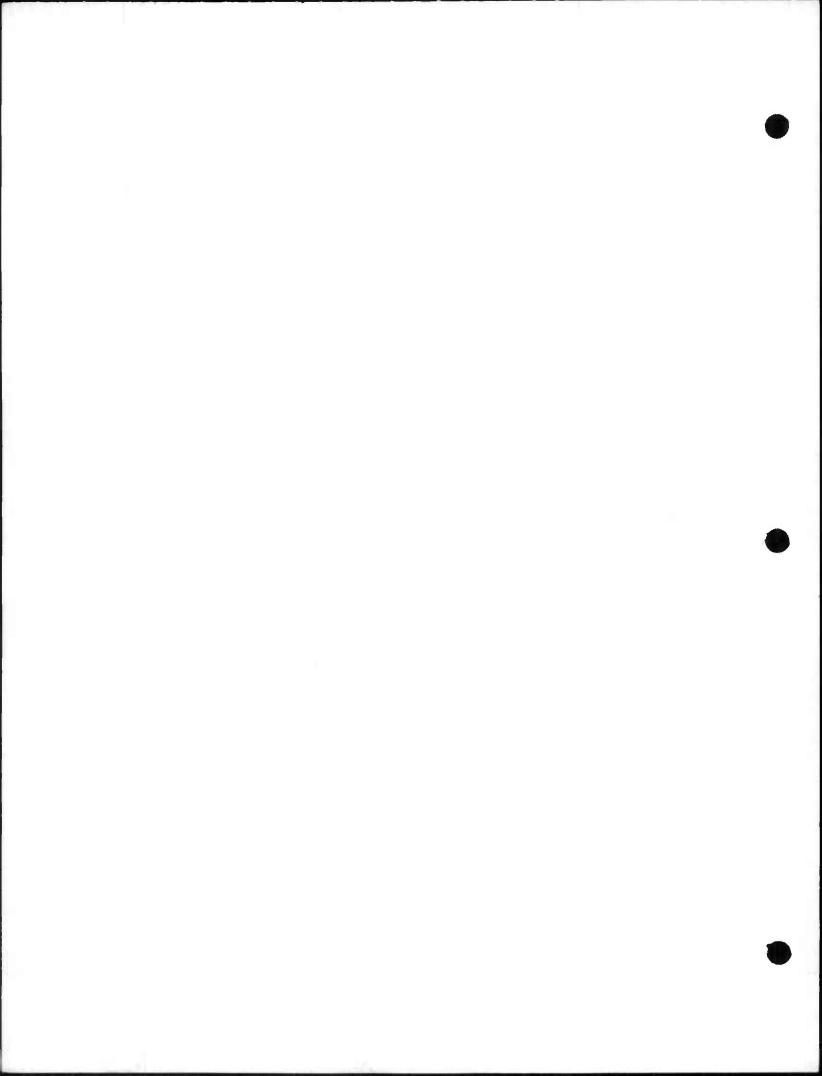
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4 32: REGISTRAR'S SIGNATURE

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -**CERTIFICATE OF DEATH** REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN 31 1993 Margaret 03 Yeakel P ,M 3:30 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. S. BIRTNPLACE (State or Foreign 1 [] M 2 [] F YRS. 79 7-<u>6-1913</u> 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN FUNERAL DIRECTOR 1319 Hillman Court Baltimore City RESIDENCE OF DECEDENT 10e. STATE 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore na 1 YES 2 NO 10e. STREET AND NUMBER 10f, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1319 Hillman Court 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No-if yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried BY 1 YES 2 NO Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working (Specify only highest grade completed) (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 17. FATNER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Melden Surname) BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE 5 Dower (Specify) in state removal HOMETURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Ronald Wade, Dir State Anatomy Board 4/7/93 655W.BaltimoreSt,Balto,MD 21201 PART I. Enter the diseases, or consilications that ceused the deeth. Do not enter the mode of dying, such as cardiec or reepiretory arrest, Approximate shock, or heart fellure. List only one cause on each line. interval Betwe IMMEDIATE CAUSE (Fine) Onset and Death disease or condition rtenosclerotie Cardiovascular disease resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other significent conditions contributing to deeth but not recuiting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION DF CAUSE 1 TYES 2 NO OF DEATH? 1 TYES 2 T NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) HOSPITAL: OTHER: 1 XYES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 ☐ Nursing Nome 5 🂢 Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 26a. OATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED 1 Natural 2 Accident 5 Pending BY 1 YES 2 NO 26e. PLACE OF INJURY — At home, ferm, street, lectory, office building, stc. (Specify) 3 Suicide 26f. LOCATION (Street and Number or Rural Route Number, City or Town. State) 6 Could not be 4 Nomicide determined Ш 29e. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated. COMPL 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. BE 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) 04/01/1993 O.C.M.E. 2 WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

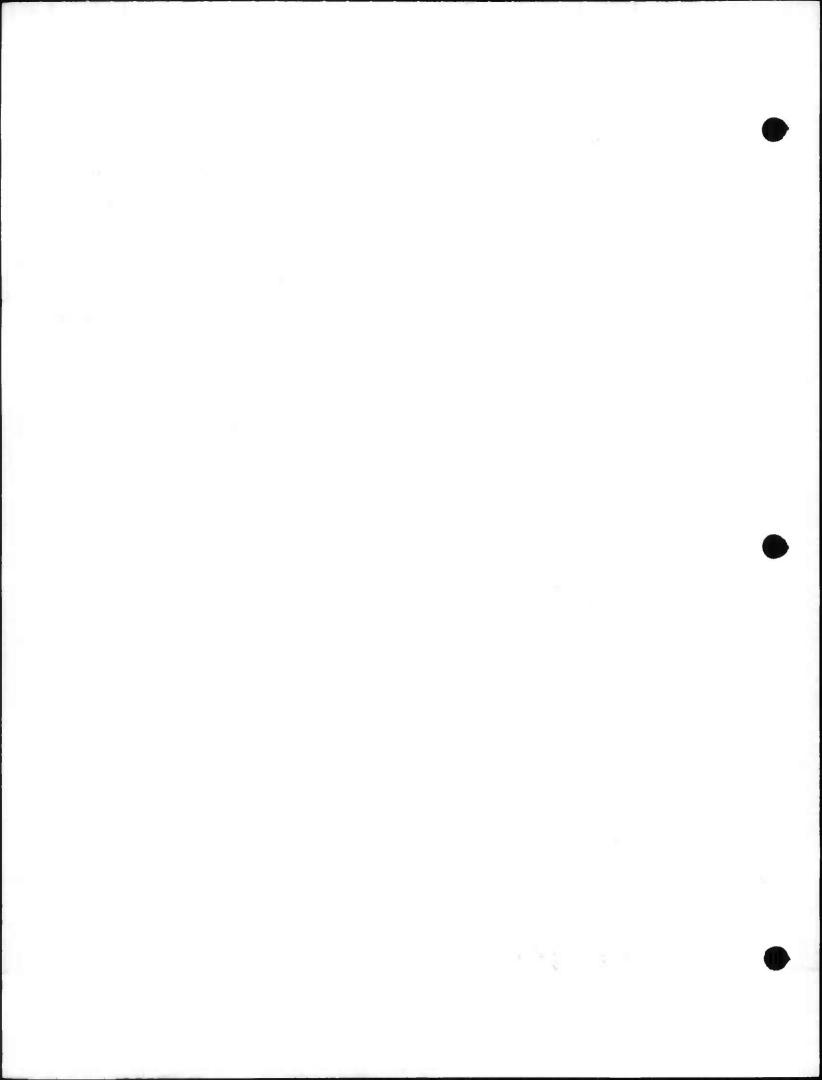
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BALTIMORE, MARYLAND 21215-0020	fler death. Page 6 may be retained by the hospital or attending physician.	the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should oval.	al examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE MENT ALL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	48. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: If Itom 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	

	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Last)  MARY L. YOUNG					2. DATE OF DEATH	MY 1993 YEAR	3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER 5. SEX 1 M 2 X X S 88 YRS.  6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR   IF UNDER 24 HRS.   7. DATE OF BIRTH AND AND AND AND AND AND AND AND AND AND										
TOR	9a. FACILITY NAME (If not institution, give street and number)  THE JOHNS HOPKINS HOSPI  RESIDENCE OF DECEDENT	TAL	91	BALT	NORE	ATH	9C. COUNTY OF DEATH BALTIMORE CITY				
DIRECTOR	10a. STATE 10b. COUNTY	1.00	10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? 1 X YES 2 NO				
FUNERAL	701 N. ARLINGTON AVE.			101	21217		10g. CITIZEN OI	USA			
B	11. MARITAL STATUS  1 Never Merried 2 Married  3 Widowed 4 Divorced  12. WAS DECEDENT. FORCES? 1 IF YES, GIVE WAI	YES 2	X NO	If yes, spe		IC ORIGIN? (Specify Ye i, Puerto Rican, atc.)	s or No— 14. RACE — American Indian, Black, White, etc. Specify:				
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	184	(Give kind of work life. Do NOT use re	done during mos		16b, KIND OF BU	SINESS/INDUSTRY				
BE COM	17. FATHER'S NAME (First, Middle, Last) PHILLIP JOHNSON				18. MOTHER'S NAM	ME (First, Middle, Meiden HOMAS	Surname)				
10	EDITH CAPESTANY		196. MAILING AD 2030 M			BALTO.,	MD 2	1217			
	20e, METHOD OF DISPOSITION  1 © Burlet 2 Cremation 3 Removal from State  20b. PLACE AND DATE OF DISPOSITION (Name of camelony, crematory or other place).  With Auburn Cemetery 41093 Baltimore,										
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  MARCH FUNERAL HOME - WEST  4300 WABASH AVE. BALTO., MD 21215										
	23. PART i. Enter the diseases, or complications that of shock, or heart feiture. Liet only one cause IMMEDIATE CAUSE (Final disease or condition resulting in death)  DUE TO (O	on each	iine.					Approximate interval Between Onset and Death  3 WKS.			
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST  b. DUE TO (OR AS A CONSEQUENCE OF):  C. DUE TO (OR AS A CONSEQUENCE OF):  d.										
PHYSICIAN: MEDICAL C	PERFORMED?  1 YES 2 NO COLOR						4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2				
25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 VES 2 NO											
BY PHY	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation  28a. DATE OF INJURY AT WORK? 1 YES 2 NO  28b. TIME OF INJURY AT WORK? 1 YES 2 NO										
3 Suicide 4 Homicide 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 28e. PLACE OF INJURY — At home, ferm, street, factory, office City or Town, State)  28e. Certification (Street and Number or Rural Route Number, City or Town, State)  28e. Certification (Street and Number or Rural Route Number, City or Town, State)  28e. Certification (Street and Number or Rural Route Number, City or Town, State)  28e. Certification (Street and Number or Rural Route Number, City or Town, State)								I Route Number,			
	(Check only one)  2 MEDICAL EXAMINER: On the basic of example of example of the basic of example of				ath occured at the t	lme, date and place, ar	nd due to the cause				
TO BE	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE	M.	(ITEM 27) (Type, Prir	76)	29c. LICENSE NUMI	BER	▶ 4/3	93			
	SI. DATE FILED (Morit), Day, Year)  ADD 08 1993  Author January	M	RE		ver Jo	has Hoglem	bypila	l Bult Mozins			



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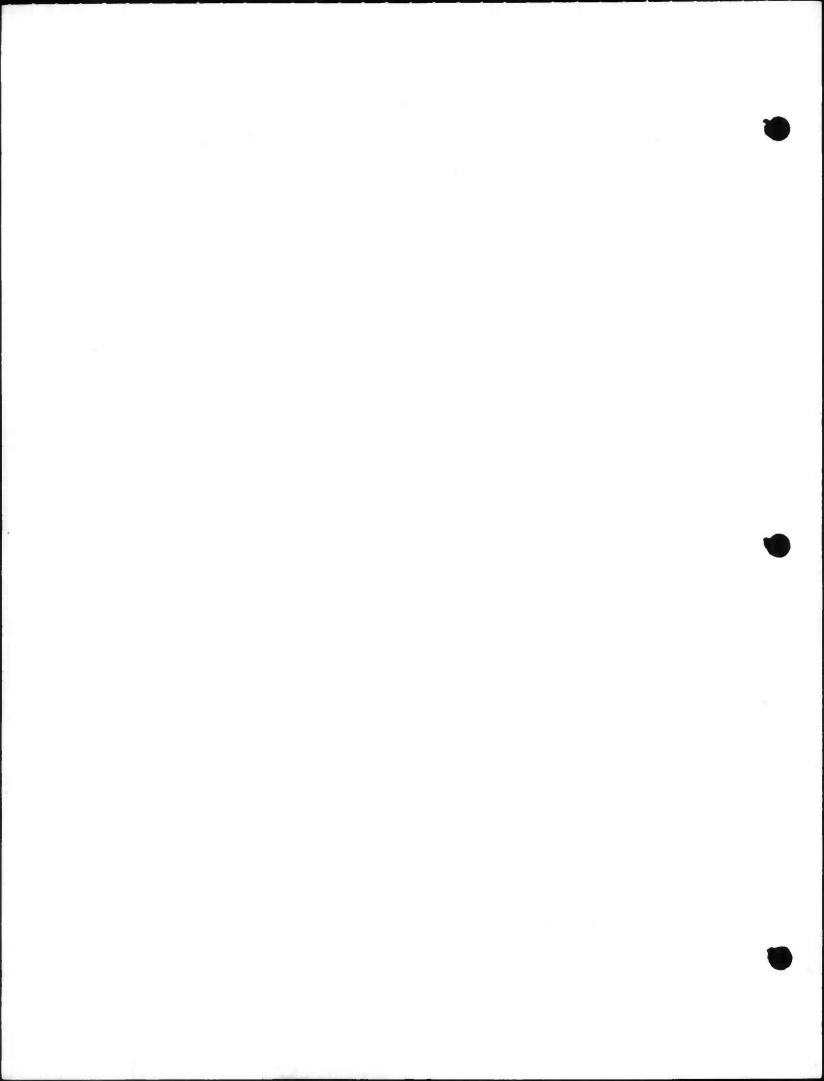
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH YEAR Joseph Peter April 1, Zeman 12 Noon 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year)
DEC. 7, 1 IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) 215-16-5706 DAYS 1 🔀 M 2 🗌 F YRS. 1921 Maryland use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF GEATH DIRECTOR 2739 Chesley Ave. Baltimore RESIDENCE OF DECEDENT 10h COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Baltimore 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 2739 Chesley Ave 21234 S after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? XX YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried If yes, specify Cuben, Mexicen, Puerto Ricen, etc.)

1 YES 2 NO Specify: BY IF YES, GIVE WAR OR DATES Specify: 3 Widowed 4 Divorced White WII COMPLETED 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INOUSTRY (Specify only highest g Elementary/Secondary (0-12) NA è NA (1-4 or 5+) Police Officer Baltimore City detached 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Frank J. Zeman page 5 should be Ħ Barbara A. Janecek BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2 Irene M. Zeman (Wife) 2739 Chesley Ave., Baltimore, Md. 21234 pe 20e. METHOD OF DISPOSITION
1 N Burlal 2 Cremation 3 Removal from State
4 Donation 5 Dother (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE director, p must Gardens of Faith Cemetery 14/3 Baltimore, Md examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE n by the funeral d removal. 22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home 3331 Brehms Lane, Baltimore, Md 21213 medical 23. PART i. Enter the diseasee, or complications that caused the death. Do not enter the mode of dying, such ea cerdiac or reapiratory arrest, shock, or heart failure. List only one cause on ascipline. filled in by Approximata Interval Between **IMMEDIATE CAUSE (Final** completely filled rial, cremation, Onest and Death the disease or condition metastatie adend carcinoms of mo resulting in death) executed within event. DUE TO (OR AS A CONSEQUENCE OF and con o burial, traumatic CERTIFICATION Sequentially list conditiona, QUE TO (OR AS A CONSEQUENCE OF) by the attending physician a and Mental Hygiene prior to if any, leading to immediate cause. Entar UNDERLYING requires that the death certificate be other CAUSE (Disease or Injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMEO? WERE AUTOPSY FINDINGS shows any AVAILABLE PRIOR TO COMPLETION DF CAUSE been signed to 1 YES 2 NO OF DEATH? 1 YES Z NO Dept. HOSPITAL OR ATTENDING PHYSICIAN: The law 25. WAS CASE REFERRED TO MEDICAL th the State D 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 1 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED marked, this with 5 Pending Investigation T-Natural 1 YES 2 NO After ti BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 3 Suicide DIRECTOR: A hours after de lem 28 is 49 ETED. 8 Could not be 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4 Homicide COMPL CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date end place, end due to the cause(s) end menner as stated. TO THE FUNERAL IDE filed within 72 h (Check only one) CAL EXAMINER: On the basic of examination end/or investigation, in my opinion, de occured at the time, date end place, end due to the cause(e) end menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIS 29c. LICENSE NUMBER 표분 223 9 PLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Richard Huslig Odea Building, Suite 504, 7505 Osler Dr., Towson, Md. AL DATE FILEO (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Davidson Mandale

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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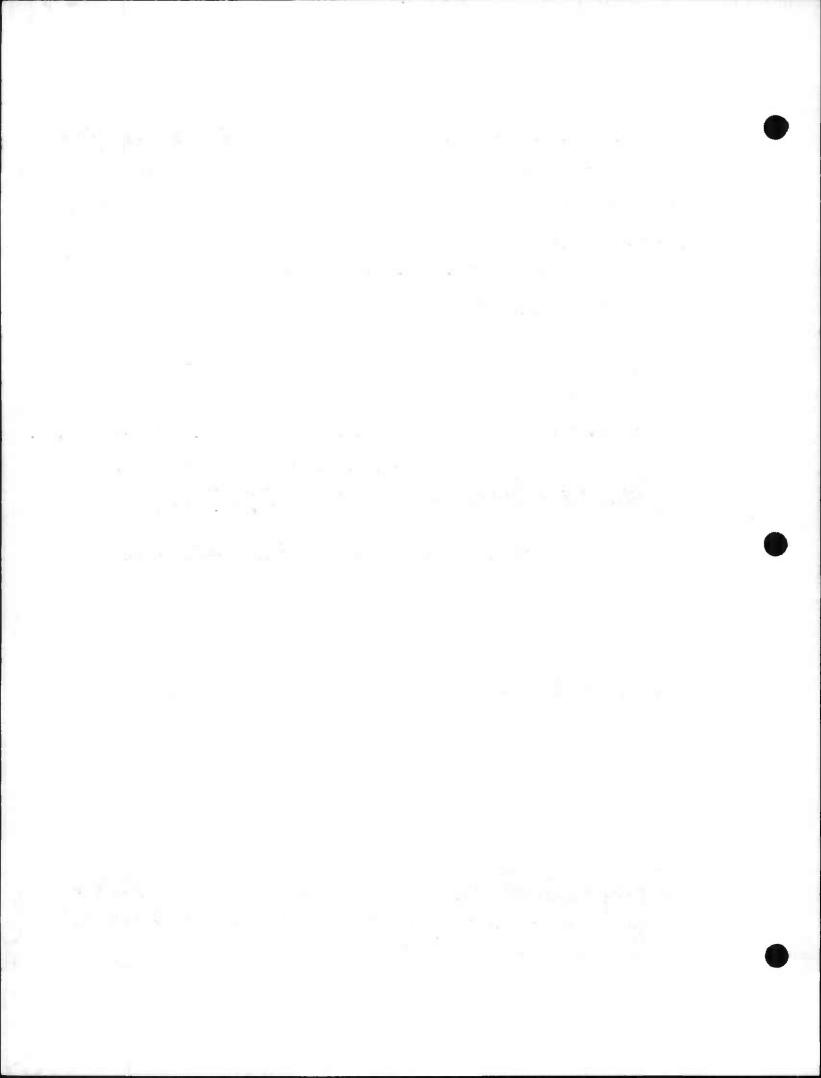
		1 - FOR STATE (	OF MARYLAND / DEPAR	RIMENT OF H	EALTH AND ME	NTAL HYGIENE REG. NO.		0 0 0 1 0
		1. DECEDENT'S NAME (First, Middle, Last)			2.	DATE OF DEATH MONTH DAY	YEAR	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs. last birthday)	emski S		April 4	1993	2020 P
		212-20-4652 15m 2 C		MONTHS DAYS	HOURS MIN.	(Month, Day, Year)	Country)	
pinous		9e. FACILITY NAME (If not institution, give street and number		9b. CITY, TOWN C	OR LOCATION OF DEATH		923 Sc. COUNTY OF DEA	Maryland
1, 2, 3 s	TOR	Peninsula Regional M	edical Center	Sali	sbury		Wicomi	co
permit. Pages	DIRECTOR	100. STATE 10b. COUNTY Maryland		y, TOWN OR LOCAT				IOd. INSIDE CITY LIMITS? TE YES 2 NO
ışi	ERAL	100. STREET AND NUMBER  Dundalk Avenue 160	9		21222		10g. CITIZEN OF WH United	AT COUNTRY?
215-0020 attending physician. use as the burial-transit	BY FUNER	3 Widowed 4 Divorced	EOENT EVER IN U.S. ARMED  1 🖄 YES 2 🗆 NO  IVE WAR OR OATES  KOLOA	If yes, spi	ENDENT OF NISPANIC Coeffy Cuban, Mexican, Pt 2 NO Specify:	ORIGIN? (Specify Yes o uerto Rican, etc.)	14. RACE - Black, Specify: WIL	- American Indien, White, etc.
	ETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. OECEDENT'S (Give kind of s	USUAL OCCUPATION		16b. KIND OF BUSIN	NESS/INDUSTRY	
Q = 10	PLE	Elementary/Secondary (0-12) College (1-4	Inspect		•	Gener	al Moto	rs
LAND of the hospital e detached for	COMPL	17. FATHER'S NAME (First, Middle, Last)			18. MOTNER'S NAME (			
2 2 2 1	61		emski		Cather	ine	Kord	ynska
E, MARN y be retained to sage 5 should	101	Marcella T. Ziems	ki Dund	alk Ave	nd Number or Aural Route enue 1609	Number, City or Town, Balto.	State, Zip Code) , Md. 2	1222
6 ma ector, p		20s. METHOD OF DISPOSITION 1 Duriel 2 Cremation 3 Removal from Stat 4 Donation 5 Other (Specify)	20b. PLACE AND DATE OF SAC LEGY OF				ation - city or Town.dalk, M	aryland
- 97		Mark C. Se	machi	V. Dabi	rowski/Ci Dundalk A	Yojnacki Ave. Bal	F.H. P	.A. . 21224
o.O. BOX 68760, rentificate be executed within 24 nours aft nding physician and completely filled in by Hygiene prior to burial, cremation, or remore other traumatic event, the medical or other traumatic event, the medical control or other traumatic event.			That caused the deeth. Do not cause on each line.  Prioscloretic ( E TO (OR AS A CONSEQUENCE OF	Cardiovas			tory erreat,	Approximate interval Between Onset and Death
	RTIFIC	cause. Enter UNDERLYING CAUSE (Disease or Injury	E TO (OR AS A CONSEQUENCE OF					
the death y the atten of Mental H	ابا	PART II. Other significant conditione contribution	g to death but not reaulting i	in the underlying	cause given in Part			/ERE AUTOPSY FINDINGS
WECORE v requires that the been signed by and it, of Health and shows any in	ME					1 TYES 2	NO C	WAILABLE PRIOR TO OMPLETION OF CAUSE OF DEATH?  YES 2 NO
The law tite has b ate Dept.	1 3 1	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			ACE OF DEATN (Check o	nly one)		
VI CIAN: ortifical he Sta	PHYSIC	1 X YES 2 □ NO 1 □ Inpetient	2 ER/Outpetlent 3 X DOA	OTHER: 4 Nursing Home	5 Reeldence 6	Other (Specify)		
After this of death with the marked.	ВУ РН		E OF INJURY 26b. TIM INJ	URY WO	JRY AT 28d RK? ES 2 NO	I. OEŞCRIBE NOW INJ	URY OCCURED	
TTENDI TTENDI CTOR: A after de	0	3 Suicide 8 Could not be 4 Nomicide determined	CE OF INJURY — At home, farm, a ding, etc. (Specify)	treet, factory, office	281	LOCATION (Street and City or Town, State)	l Number or Rural Rou	ite Number,
7 7 7	. 1 == 1	29e. CERTIFIER (Check only one) 1 CERTIFYINO PNYSICIAN: To the be						and manner es stated.
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: II	BE CO	29b. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NUMBER		29d. DATE SIGNED (M	
TO THE HOSPITA TO THE FUNERA DE filed within 7	T0.8	30) NAME AND ADDRESS OF PERSON WHO COMPLETED	Deputy, M.E.	Print)	D03599		4/3/93	
		John T. Bulkeley, M.D.			Saliahur	, Mm 210	201	
		APR 08 1993	Jacydson Agnosia	a Rodu.	Darrsbury	218	W.I	
	البسا	7 1000						

		1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPART			MENTA	L HYGIENI REG. NO.	Ε (	3	09950			
	1	1. DECEDENT'S NAME (First, Middle, Last)  ER VEST V  4. SOCIAL SECURITY NUMBER	JK 130	Baugh FUNDER 1 YEAR IF UNDER 24 HRS. 7 DATE OF BARTH A BARTHER			TIME OF OEATH  S  M  ACE (Stata or Foreign							
3 should	Œ	213-03-2585 9a. FACILITY NAME (If not institution, give in	1 If M 2 □ F 93	YRS.	DAYS DAYS DO. CITY, TOWN C	HOURS MIN.	12	Day West	99 9c. COUNT	Y OF OEAT	D H			
Pages 1, 2, 3	DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNT  MONEY   20 d		1-1	TOWN OR LOCAT				Ba	10	MO / C.  d. INSIDE CITY LIMITS?			
	ERAL D	Maryland Balt  10. STREET AND NUMBER  3219 Chesley Ave			101	. ZIP CODE 21234			10g. CITIZE	N OF WHA	T COUNTRY?			
215-0020 attend	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 NO	If yes, spi	ENCENT OF HISPA ecity Cuban, Mexico 2 NO Special	an, Puerto I		or No — 1	Specify: Whit	American Indian, /hita, etc.			
Par of A	PLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed)  College (1-4 or 5+)  4 YYS	Ille. Do NOT use	rk done during mo-	st of working	16b	Balti	more					
IARYLAND 2 rtained by the hospital should be detached to	BE COMPL	17. FATHER'S NAME (First, Middle, Last) Ernest Vancliv  19a. INFORMANT'S NAME (Type/Print)	ve Baugh,Sr.	T			hine	Emma C	Croft					
y be re	10	Christina Baugh		3219	Chesley			nore, M		234	State			
ALTIMO death. Page 6 tuneral direct		4 Donation 8 Oliver (Specify)  21. SIGNATURE OF FUNERAL SERVICE LIE		itery, crematory or othe illtop Se	22. NAME AN	corp.  B ADDRESS OF FA  Towson  York Rd	Fune	cal Hon		c.				
OX 68760,  be executed within 24 nours effer d ician and completely filled in by the vior to burial, cremation, or removal.  traumatic event, the medical ex	NOIL	23. PART I. Enter the diseases, or shock, or heart fellure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. DUE TO (OR AS A COUPLING	the death. Do not children.  CONSEQUENCE OF):  CONSEQUENCE OF):	t enter the mo						Approximate interval Between Onset and Death			
h certificate anding phys Hygiene p	CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A (	CONSEQUENCE OF):										
record the requires that the een signed by the of Health and M shows any Injury	MEDICAL	MEDICAL	MEDICAL	MEDICAL	PART II. Other algorificent condition	a contributing to death bu	t not reaulting in	the underlying	g couse given in	Part I.	24a. WAS AN / PERFORI	MED?	AM CC OF	ARE AUTOPSY FINDINGS ARLABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO
VIIAL  JIAN: The lav ritificate has he State Dep or Item 23	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO	HOSPITAL: 1 Nonpetient 2 - ER/Outpe		OTHER:	ACE OF DEATH (C)								
NG PHYSIC fler this cer eath with th	ву РН	27. MANNER OF DEATH  1	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME (	WO WO	URY AT PK? 'ES 2 NO	28d, DES	CRIBE HOW IN	JURY OCCU	RED				
DIVISION DR ATTENDING DIRECTOR: After hours after death item 28 is ma	0	3 Suicide 6 Could not be detarmined 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  28s. LOCATION (Street and Number or Rural Route Nu City or Town, State)						a Number,						
Check only (Check only Check on Check											id manner as stated.			
TO THE HOSPIT TO THE FUNERA DE filed within 7 IMPORTANT:	TO BE (	296. SIGNATURE AND TITLE OF CERTIFIE	in		/ 0/				onth, Day, Year)					
		30. NAME AND ADDRESS OF PERSON WH	NUSAIR	EGM.D.		seph Hos	pital	, Tows	on, M	ıd.				
		31. DATE FILED (Month, Day, Year)  APR - 9 1993	32. REGISTRAR'S SIGNA	TURE										

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DIVISION OF VITAL RECORDS, P.O. BOX 66/60	HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the dean or
5	OR.
	<b>HOSPITAL</b>

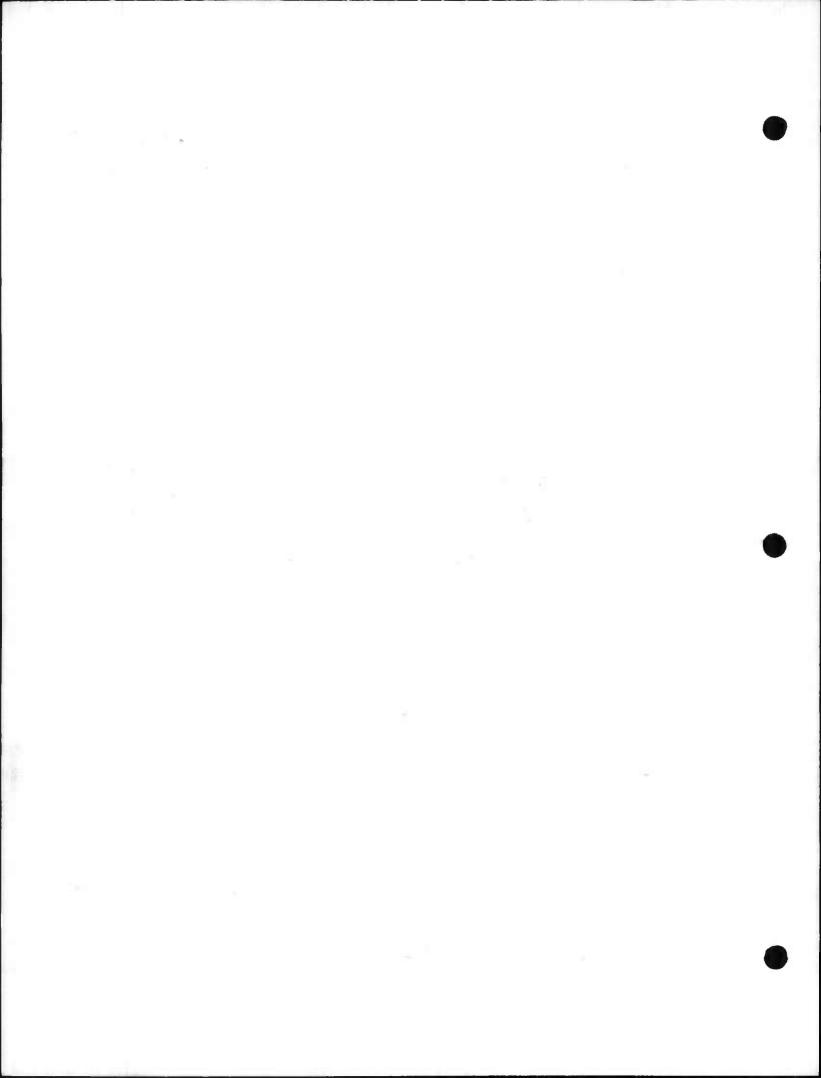
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the hospital detached	COMPLETED	17. FATHER'S NAME (First, Middle, Last)	
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should the	BE	19a. INFORMANT'S NAME (Type/Print)	
retained 5 should notified	9		,
ay be re page 5:		Dorthy I. Bet	cher
e 6 may be ector, page		20a. METHOD OF DISPOSITION 1, Description 2 □ Cremation 3 □ Ram	noval from
lirect		4 Donation 8 Other (Specify)	
aral d	l j	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE
The first of the control of the cont	- 8	>1/84/110N/an	P HOU
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usurs after d in by the or remova		shock, or heart failure.	
24 h		iMMEDIATE CAUSE (Finei disesse or condition	1
1 1 1 1 1		resulting in death)	· AN
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1000	Z	Sequentially list conditions,	b
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the car	E	resulting in death) LAST	d
the dearly the attended injury.	2	BART II Oh - I - III - A - III	
HYSICIAN: The law requires that the death cent is certificate has been signed by the attending with the State Dept. of Health and Mental Hygined, or Item 23 shows any Injury, or or	AL	PART ii. Other aignificent condition	_ ,
s that ned by lifth and any	8	Acute Tub	ULAI
requires sen sign of Heal	끻		
PHYSICIAN: The law requires that the deam cent this certificate has been signed by the affecting with the State Dept, of Health and Mental Impur riced, or Item 23 shows any injury, or on	PHYSICIAN: MEDICAL CERTIFICATION		
he law has b e Dept.	₹	25. WAS CASE REFERRED TO MEDICAL	
N: The ficate h State [	S	EXAMINER?  1 YES 2 NO	HOSPI*
PHYSICIAL this certif with the rked, or	Ě	27. MANNER OF DEATN	28a.
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ma ma	B	2 Accident Investigation	-
OR ATTENDING DIRECTOR: After hours after death	0	3 Suicide 6 Could not be 4 Nomicide determined	28a.
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L OR A DIREC hours	1	29a. CERTIFIER 1 CERTIFYING PHYS	CIAN: To the
TO THE HOSPITAL OR ATTENDING TO THE FUNERAL DIRECTOR: After be filed within 72 hours after death IMPORTANT: If item 28 is ma	COMPLETE	one) 2 MEDICAL EXAMINE	R: On the b
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FOR STATE REGISTRAR		STATE OF I	MARYLAI	ND / DEPAI CERTIF					MENTAL HYGIEN	_	09	1951	
1. DECEDENT'S NAME (First,	, Middle, Last)		-						2. DATE OF DEATH	AY		3. TIME OF DEATN	
Myles			r B	PETCH	EL				04 o:		YEAR	1736 M	
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (in	yrs. last birthday)	IF UNDER					LACE (State or Foreign			
158 14 90		1 🖳 M 2 🗆 F	68	B YRS.	minerales.	MONTHS DAYS HOURS MIN. April 24					177"		
9a. FACILITY NAME (If not in	stitution, give s	treet and number)			9b. CITY	, TOWN	OR LOCATI	ON OF DE	ATH		TY OF DEA		
Shady Grov	re Adv	ventist	Hosi	oital	R	ock	vill	e		Mor	ityo	mery	
10a. STATE	10b. COUNTY			10c. Cl	FY, TOWN	OR LOCA	TION				T <sub>1</sub>	IOd. INSIDE CITY	
Maryland	Mont	tgomery		6	ath	are	burq					LIMITS?	
10e. STREET AND NUMBER							of. ZIP COD	E		10g. CITIZ		AT COUNTRY?	
880 Quinc	ce Ord	chard B	lvd.	Apt. T	-2		20	878		US	A		
11, MARITAL STATUS		12. WAS DECEDEN	T EVER IN U	S. ARMED					IIC ORIGIN? (Specify Yes	or No	4. RACE -	- American Indian, White, atc.	
3 Wildowed 4 Discorped IF YES, GIVE WIRR OR DATES 1 YES 2 ND Specify: Specify:													
					_							hite	
(Specify only	EDENT'S EDUC y highest grade	completed)		Give kind of life. Do NOT u	work done	CCUPAT during m	ION lost of workin	ng	16b. KIND OF BUS	SINESS/INDU	STRY		
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17. FATHER'S NAME (First, Mi	iddle, Last)						T	MED'S NA	ME (First, Middle, Malden	C			
John Bet	cher											÷	
19a. INFORMANT'S NAME (7)				19b. MAILING	ADDRES:	S (Street	and Number	or Rural I	erime Ma:	n State Zin (	2 1 1 1 1	ips	
Dorthy I.		cher		880	Qui	nce	Orc		d Blvd.	Caith	ners		
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*//Alle	Nau	Parket	1	-		Ar	ling	ton	son Fune: , va. 22	201			
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Sequentially list conditi if any, leeding to immed cause. Enter UNDERLY! CAUSE (Disease or Inju- that initiated events resulting in death) LAS'	diate NG ry			DNSEQUENCE O									
PART ii. Other aignifice	nt condition	contributing to	deeth but	not resulting	In the ur	deriyir	g ceuse (	lven in	Part i. 24a. WAS AN	AUTOPSY	24b. W	PERE AUTOPSY FINDINGS	
Acute	Tube	Ular	Ne	ROS	is				PERFOR  1   YES 2		0	WAILABLE PRIOR TO OMPLETION OF CAUSE IF DEATH?  YES 2 NO	
25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:			OTHE		LACE DF D	EATN (Che	ck only one)				
1 YES 2 NO		1 Inpatient 2			4 🗆 Nur		ne 5 🗆 Re	sidence	6 Other (Specify)				
	Pending investigation	28a. DATE OF (Month, D		28b. Till IN.	JURY M	W	JURY AT ORK? YES 2	NO	28d. DESCRIBE NOW II	NJURY OCCU	RED		
3 Suicide 6 (	Could not be detarmined	28a. PLACE O building,	F INJURY — etc. (Specify)	Al home, farm,	streal, fact	ory, offic	De .		28f. LOCATION (Street a City or Town, State)	nd Number o	Rural Rou	ite Number,	
									to the cause(a) and man			nd manner on attack	
29b, SHANATURE AND TITLE					211 117 3								
DELOGIA DOMESS DE	2/2	vole.	735	),			26	MSE NUM	13	14	3/	191th, Day, Year)	
GAR GONY	//	Fishe		1 (ITEM 27) (Type	15 A	25	Shna	Dy C	snove Al	lock	ville	md.	



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		FOR STATE REGISTRAR	STATE OF N		/ DEPAR					MENTAL HYG		3 (	09952
		1. DECEDENT'S NAME (First, Middle, Last)			OLITTI	IOAIL	_ 01	DLA	···	2. DATE OF DEA	тн	T	3. TIME OF DEATH
		<u>Judith-Ann</u> Burl	(e							March 2	25, 199	3 YEAR	9:00 P
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.		IF UNDER	1 YEAR	IF UNDER	MIN.	7. DATE OF BIRT	H	6. BIRTH Country	PLACE (State or Foreign
Pa		577-14-1909	1 □ M 2 X (F	73	YRS.					12-23-	[9		hington DC
2. 3 should	POR	9a. FACILITY NAME (If not institution, give sti  506 Prince George RESIDENCE OF DECEDENT	A				Laur	_	ION OF DEA	ATH		rince	e George
es 1.	DIRECTOR	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN C	OR LOCAT	ION					10d. INSIDE CITY
rmit. Pag		Maryland Princ	ce George	5	L	aure	_	. ZIP COD					1XX YES 2 NO
an. ransit pe	FUNERAL	506 Prince George					2	0707			US		/HAT COUNTRY?
BALTIMORE, MARYLAND 21215-0020 in death. Page 6 may be retained by the hospital or attending physician. The formul director, page 5 should be detached for use as the burial-transit permit. Pages 1. In terminer must be notified at once.	В	11. MARITAL STATUS 1 Never Married 2 Married 3 Midowed 4 Divorced	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES 2	ARMED (NO		if yes, sp	ecity Cuba	OF HISPANI an, Maxican Specify:	C ORIGIN? (Speci , Puerto Rican, st	fy Yes or No— c.)	14. RACE Black Specif	- American Indian, White, atc.
215 atten	ETED	15. DECEDENT'S EDUC (Specify only highest grade	ATION completed)	DECEDENT'S	NT'S USUAL OCCUPATION d of work done during most of working OT use retired.)				16b. KIND O	F BUSINESS/IN	DUSTRY		
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LAN the ho	Ö	17. FATHER'S NAME (First, Middle, Last)								IE (First, Middle, M	alden Surname)		
RYL ed by uid be	8	Robert Bealle  19a. INFORMANT'S NAME (Type/Print)		-					rianne Cassidy or Aural Route Number, City or Town, State, Z				
	5	Joyce Ann Albaugh	1		1248	9 We	st N	ugge	t Col	urt Hig	ghland,	MD	20777
BALTIMORE, after death. Page 6 may be more: cal entering director, page cal entering must be in		20a, METHOD OF DISPOSITION    Burlel 2   Cremellon 3   Ramo	val from Stata		cremetory.oco						c. LOCATION —		
um. Page meral dray		4 Donation 6 Other (Specify)  21. SIGNATURE OF FUNERIAL SERVICE LIGHT	DARREE ()	Teda	ir HII		nete		SS OF FAC		uitian	a, Ma	aryland
ALT Seeth.	$\overline{}$	· Valale	to, Upan	da						Home, I			
By duby the or namoed		23. PART I. Enter the diseases, or co	omplications that	Caused the	Math. Do i	not enter	the mo	Sand de of dv	V Spr	es cerdlec or	respiretory er	rel.	MD 20707 Approximate
n 24 arion, the		shock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	rat duty one cap	Alas (OR AS A CON	100								Interval Between Onset and Death
BOX 68760, and the executed with hydician and complete to prior to burial, crem in traumatic event.	RTIFICATION												
, P.O. seth certific this model of tal Hygient K, or other	CERTIF	that initiated events resulting in deeth) LAST	DUE TO	(OR AS A CON	SEOUENCE O	F):							
The o		PART ii. Other significant conditions	contributing to	death but no	t resulting	in the un	derlying	ceuse (	given in P	Part I. 24a. W	AS AN AUTOPSY	24b.	WERE AUTOPSY FINDINGS
RECORI requires that sen signed by of Health and shows any I	MEDICA									PE	RFORMED?		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
L R See of E										_			
TTA N The Ichte ha	SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER	R:		EATH (Chec				
o the state of	PHYS	27. MANNER OF DEATH	1 Inpatient 2 I	INJURY	28b. TIM	E OF	28c. INJI	URY AT		Other (Specify 28d. DESCRIBE H		CURED	
The state of the s	ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Da	sy, 16ar)	INJ	M M		RK? 'ES 2	NO				
2 1 2 2	ETED	3 Suicide 6 Could not be 4 Homicide determined	26a. PLACE OF building, a	F INJURY — At atc. (Specify)	home, farm,	street, fact	ory, office			281. LOCATION (S City or Town,	treet and Numbe State)	r or Runal Re	oute Number,
TAL OR AND DIRECT TO THE TENT OF THE THE THE THE THE THE THE THE THE THE	COMPLE	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC											
TO THE HOSPITAL TO THE FUNERAL Se filed within 72 IMPORTANT; If	8	2 MEDICAL EXAMINER  29b. SIGNATURE AND TITLE OF CERTIFIER	. On the basis of ax	amination and/	or investigation	m, in my o	pinion, de		ed at the ti				and manner as stated. (Month, Day, Year)
TO THE DE STREET TO THE DE STREET STR	TO BE	A. Mendeus						13	671	16	<b>b</b>	7/26	193
in		30. NAME AND ADDRESS OF PERSON WHO		3/7	TEM 27) (Type,			ANE	, 6.	ANRE	MI	1 20	707
10		31. DATE FILED (Month, Day, Year)  APR - 9 1993	32. REGISTRAF	R'S SIGNATURE									
	الـــــا	- H II II II II II II II II II II II II I	0				_						



			REGISTRAR		CE	RTIFICAT	E OF	DEATH		REG. NO			
		- 3	1. DECEDENT'S NAME (First, Middle, Last)					· · · · · · · · · · · · · · · · · · ·	2. DATE (				3. TIME OF OEATH
		1	CHARLES C BAK	ER / CHARL	ES C	OFFMAN	BA	KER	04	08	AY	993	1230 A
			4. SOCIAL SECURITY NUMBER		(In yrs. last i	birthday) IF UNDE	R t YEAR	IF UNDER 24 HRS.	7. DATE O	F BIRTH		8. BIRTHPI	LACE (State or Foreign
		- 8	216-01-9555	1 € M 2 □ F 7	4 75	YRS. MONTHS	DAYS	HOURS MIN.	06	Day, Year)	918	Vi 1	ginia
	100	l l	9a. FACILITY NAME (If not institution, give stre		1 13	9b. CIT	r, TOWN	OR LOCATION OF D		10 1		NTY OF DEA	
1	6	DIRECTOR	GREATER BALTIMORE	MEDICAL CE	NTER		owso					ALTIM	
		Ä	10s. STATE 10b. COUNTY			10c. CITY, TOWN	OR LOCA	TION				1	IOd. INSIDE CITY
1	2	8	MARYLAND BALT	IMORE		BALTI	MORE	( Roc	lgers	For	00)	ı,	LIMITS?
0-22	E	¥	10e. STREET AND NUMBER					f. ZIP COOE					IAT COUNTRY?
ian.	bunal-transit p	UNERAL	174 DUMBARTON ROA			- T.		21212				USA	
5-0020 nding physician.	bunal	ш	1 Never Married 2 Married	12. WAS DECEOENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR O	2 NO		It yes, sp	DENDENT OF HISPA Decify Cuben, Mexic 3 2 NO Speci	an, Pusrlo Ri	(Specify Yes lcan, etc.)	or No-	14. RACE - Black, Specify:	– American Indian, Whits, stc.
15-0(	as the	ВУ	3 Widowed 4 Divorced	<i>V</i>	W II			X				open,	White
21 afte	use a	ED	15. DECEDENT'S EDUC. (Specify only highest grade c	ATION ompleted)	16s. DECI	EDENT'S USUAL O	CCUPATIO	ON ost of working	16b.	KIND OF BU	SINESS/INC	DUSTRY	
2 N	<u>ŏ</u>	LET	Elementary/Secondary (0-12)	College (1-4 or 8 +)	Me. E	Do NOT use retired.)	downg m	ost or working					
ND 2	detached once.	COMPL	12th		Main	tenance	Dep	t. Manag	er Pro	octor	& Ga	umble	Manufacur:
<b>Q</b> 9	detach once.	Ö	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	AME (First, Mi	iddle, Malden	Sumame)		
<b>&gt;</b>	2 %	ш	MERVYL BAKER /	Marvyl H.	Bak	er			Stella M. Co			offm	an
MAR	5 should notified	B	19s. INFORMANT'S NAME (Type/Print)				S (Street a	and Number or Rural	Route Numbe	r, City or Tow	n, State, Zij	Code)	
atra	5 5	5	Edythe V. Bake	r									MD 21212
Page 6 may be	page -		20s. METHOD OF DISPOSITION	201		ID DATE OF DISPOS			OATE	-		City or Town	
O E	director, p		1 Burial 2 Cremation 3 Remon	rai from State	netery, crem	atory or other place)	tor	y,Inc.	1.18			more	
Page 6	dire	- 0	21. SIGNATURE OF FUNERAL SERVICE LIQUE	NOÈE MI M	2/1	OI ellia	NAME A	y, IIIC.	4/O	Б	alli	шоге	, m
ALT death.	b funeral dir I. examiner	- 3	1000	- John The	H	Ĉ	rem	NO ADDRESS OF FA	ocie	ty o.	f Md	., I	nc.
e B			George E.	MacNabb		2	99	Frederi	ck R	oad :	Balt	ο.,	MD 21228
S after	d in by the or removal. medical e		23. PART I. Enter the diseases, or co	mplications that cause	d the deat	th. Do not anter	tha mo	oda of dyling, aud	ch as cardi	ac or reapl	ratory an	reat,	Approximate
24 nours	BOE	- 1	ahock, or heart fellure. Li IMMEDIATE CAUSE (Final	at only one cause on e	each ilna.								Interval Between Onset and Death
n 24	the tile		disease or condition	CARD	IOPUL	MONARY	ARRE	ST					5 min
within	omplete il, cremi event,		reaulting in death)	DUE TO (OR AS A									2 min
executed with		Z CVA										İ	
8	ician and crior to bunite traumatic	CATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	A CONSEOU	COUENCE OF):						+	
BO S	Sicial prior trau	8	cause. Enter UNDERLYING										
. 4	the ene	RTIFIC	CAUSE (Disease or Injury that Initiated events	DUE TO (OR AS A	CONSEQU	IENCE OF):							1
7 t	Hygi e	표	resulting in death) LAST										
	ental ental	S											
a e	by the att and Menta iy injury.	DICAL	PART II. Other algnificant conditions	contributing to death b	out not rea	uiting in the ur	nderlyin	g cause given in	Part I.	24a. WAS AN PERFOR			VERE AUTOPSY FINDINGS
າ ≅	alth an	용								1   YES 2		.0	OMPLETION OF CAUSE OF DEATH?
E E	S & & E	ME											YES 2 NO
L MEC	- L O								_				
The fa	e Dept.	SICIAN:	25. WAS CASE REFERRED TO MEDICAL				26. PI	LACE OF OEATH (C/	neck only one	)			
ATTENDING PHYSICIAN: The	certificate the State the or Item	Sic		HOSPITAL:	nationt 3	OTHE	Rt:						
SICIA	the the	PHY	27. MANNER OF DEATH	28s. DATE OF INJURY		28b. TIME OF	_	te 5 Residence	_	(Specify)	N III III OO	CHRED	
S ₹	fter this eath with marked		1 Natural 5 Pending	(Month, Day, Year)		INJURY	WC	YES 2 NO	200. 0230	HIDE HOW I	NJOH! OC	CONED	
S S	After death	À	2 Accident Investigation	28e. PLACE OF INJURY	/ At hom							200	
EN O	DIRECTOR: After hours after death item 28 is ma		3 Suicide B Could not be 4 Homicide determined	building, etc. (Spec	cify)		iory, offic		City or	Town, State)	ina Number	or Rural Rou	ite Number,
OR AT	DIRECT hours a	<u> </u>			_								
- a	= 22 E	COMPLET		AN: To the best of my know									
HOSPITAL	TO THE FUNERAL be filed within 72 IMPORTANT: If	Į.	2 MEDICAL EXAMINER:	On the besis of sxamination	n and/or Inv	restigation, in my o	opinion, d	leath occured at the	time, date a	ind place, an	d due to th	ne cause(s) s	ind manner as stated.
至	HA WITH	ш	296. SIGNATURE AND TITLE OF CERTIFIER	- 0	`	11.		29c. LICENSE NU	MBER		29d. DAT	E SHONED (N	login Day, Year)
THE THE	M P S	0	lvelian .	1 Chan	er-	11 M.	0.	11/13	357		14	1/81	93
E	-0=	유	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM	(Type, Print)		11/1/	-		-	14	10
1		1	William S.	SPICED.	2/	M.A	/	BMC	,				
	-	ľ	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	IATURE .	1 70.		~ ~ /					
			, , , , , , , , , , , , , , , , , , , ,	Jan John John	- ONE								



DHMH-18 Rev 1/89

2. DATE OF DEATH 4/6/93 3. TIME OF DEATH

1 -

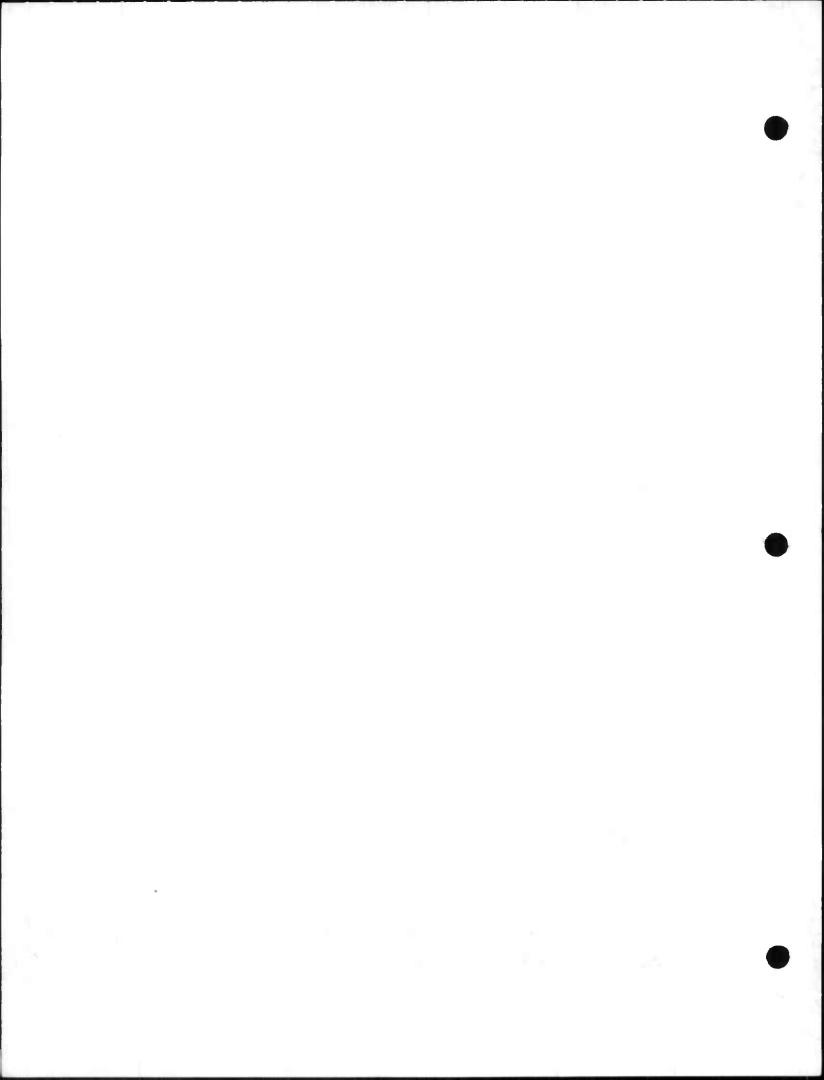
FOR STATE REGISTRAR

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

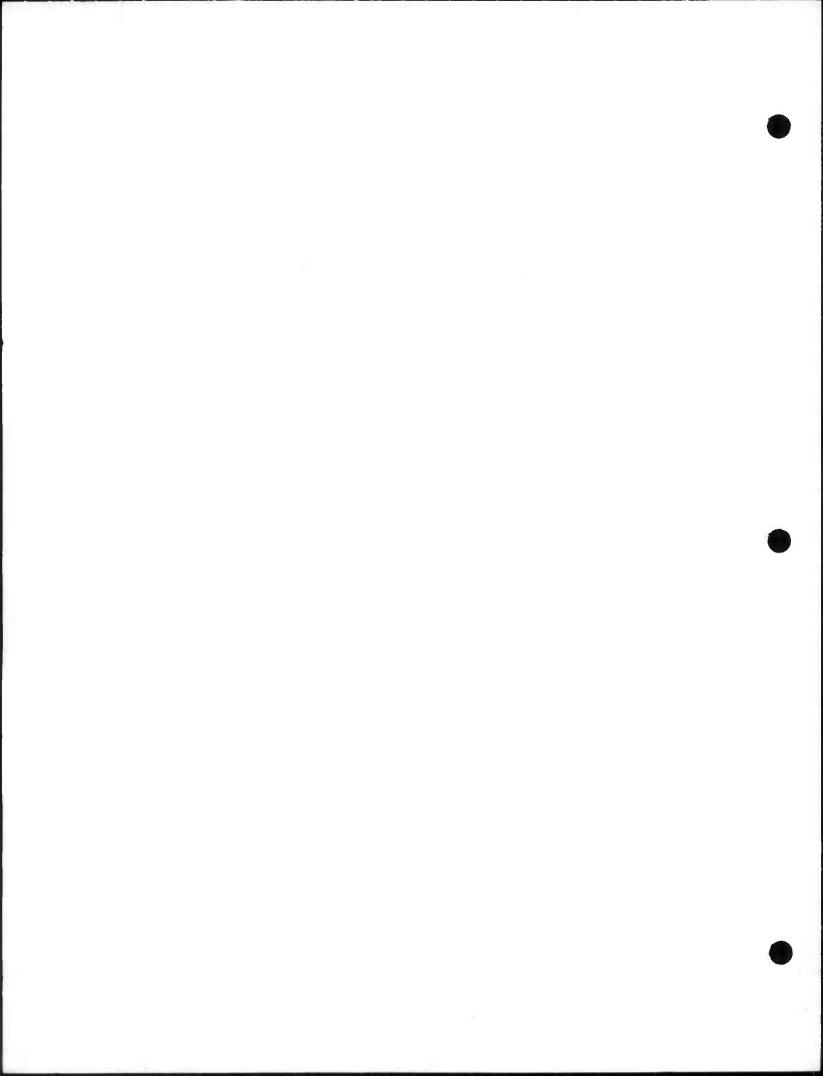
TO THE FUNEAL DIRECTOR: After this certificate be the second of the physician and completely filled in by the funeral director, page 5 should be detached for use as the business permit Pages 1, 2, 3 should be filed within the State Dear, of Health and Mental Worlden princip committees of the physician permitted or removed.

			rett	(1	ımn)		0 <b>V</b> 1S			4	-6	-9	3	18 D M
		4. SOCIAL SECURITY NUM		5. \$EX		yrs. lest birthday	IF UND	ER 1 YEAR	IF UNDER 24 HRS.	(Month	OF BIRTH , Day, Year)		8. BIRTHPI Country)	LACE (State or Foreign
	l li	481-34-49		1 🕅 M 2 🗆 F	58	S YRS.			100310	08	/21/3	34	I	owa
	OC.	9a. FACILITY NAME (If not in			_		9b. Cl		OR LOCATION OF DI	EATH		9c. COU	NTY OF DEA	ATH
	2	Anne Arun		<u>ledical</u>	Cent	ter		Ann	apolis			Anr	ne Ai	rundel
	S	10a. STATE	10b. COUNT	Y		10c. C	TY, TOWN	OR LOCAT	ION					IOd. INSIDE CITY
	DIRECTOR	Maryland	Anr	ne Arund	le1				Anna	noli	c			LIMITS?
_	¥	10e. STREET AND NUMBER						101	ZITTTC	POII		10a, CITI		IAT COUNTRY?
-		91 Charle	s Str	eet					2.14	401			USA	
- )	FUNES	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN L	U.S. ARMED	10	3. WAS DEC			0.011			- American Indian.
1	2	1 Never Married 2		FORCES? 1	1 ☐ YES 2 ☐NO  If yes, specify Cuban, Maxican, P  WAR OR DATES   If yes, specify Cuban, Maxican, P  1 ☐ YES 2 ☐NO Specify:					an, Puerto F	lican, etc.)		Black, Specify:	White, atc.
	B	3 Widowed 4 X Divo	orced						X				opoury.	White
	COMPLETED	15. DEC (Specify on	EDENT'S EDU	CATION completed)	1	(Give kind o	EDENT'S USUAL OCCUPATION  Is kind of work done during most of working				KIND OF BU	SINESS/IND	USTRY	
	<u>"</u>	Elementary/Secondary (	0-12)	College (1-4 or 5	College (1-4 or 5+)			()						
ej ej	N N	12		2		Sys	tem	<u>s An</u>	alyst		Worl	d Co	mput	ters
t once.	8	17. FATHER'S NAME (First, A									MOTHER'S NAME (First, Middle, Maiden Surname)			
ed at	H	Constantinos Boviatsis " Unknown								own t	o Re	cord	s "	
E E	2	99. INFORMANT'S NAME (Type/Print)  19b. MAILING ADDRESS (Street and Number or Rural Route Nu												
pe n		Sally Mur			1				Street					
tsn		1 Burial 2 Crematic	on 3 🗆 Ram	ovel from State	20b. P	LACE AND DAT	other place	DSITION (Na a)	me of	DATE	20c. LO	CATION —	City or Town	n, Stata
-		Metro Crematory, Inc. 4/7 Baltimore,										MD		
튑		22. NAME AND ADDRESS OF FACILITY Cremation Society of Md., In										nc.		
ex.		George E. MacNabb  299 Frederick Road Balto., MD 21228  23. PART I. Enter the diseases, Dr complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate												
edica		23. PART i. Enter the d shock, or h	iseases, Dr o	complications that List only one cau	t caused t	the death. Do	not ante	ar tha mo	de of dying, suc	h aa card	iac or respi	ratory arr	eat,	Approximata
		IMMEDIATE CAUSE (Fir		1/1	11	- 1	1	Al	11.					intarval Between Onset and Death
£ ,		disease or condition	<b>→</b>	Vyelo	dole	e 14	en	olh	liones	2				
eve				DUE TO	(OR AS A C	ONSEQUENCE	OF):							
or other traumatic event, the medical examiner must be notified	S	Sequentially list conditions,  DUE TO (OR AS A CONSEQUENCE OF):												
anu.	CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING												
je j	유	CAUSE (Disease Dr injury  that initiated events  DUE TO (OR AS A CONSEQUENCE OF):										-		
to J	E	that initiated events  resulting in death) LAST											İ	
J.		DAOT II OAN - I - III -												
shows any Injury,	MEDICAL	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMPLABLE PRIOR TO												
any	음	4 Dec 2500										C	OMPLETION OF CAUSE OF DEATH?	
NOU	ME									_				YES 2 NO
23 84	ä									_				
	5	25. WAS CASE REFERRED T EXAMINER?	O-MEDICAL	HOSPITAL:					ACE OF DEATH (Ch	eck only one	)			
or item	PHYSICIA	1   YES 2   10		1 (Varipatient 2	ER/Outpati	lent 3 🗆 DOA	4 D No		5 Residence	6 🗆 Other	(Specify)			
marked,	표	27. MANNER OF DEATH  1 Natural 5	Pending	28a. DATE OF (Month, Di		28b. TI	ME OF	28c. INJI WO		28d. DE\$	CRIBE HOW I	NJURY OCC	URED	
mar	<b>a</b>		Investigation				М		ES 2 NO					
28 Is		3 Suicide 8 Homicide	Could not be	28s. PLACE Of building,	F INJURY — etc. (Specify)	At home, farm	street, fa	ctory, office		26f. LOCA City o	TION (Street a r Town, State)	and Number	or Rural Rou	ite Number,
	ᇤ	/												
If Item	COMPL			CIAN: To the best of										
Ä	Š I	3 40	ICAL EXAMINE	R: On the basia of as	amination a	ind/or investigat	on, in my	opinion, de	eath occured at the	time, date	and place, an	d due to the	cause(s) a	nd menner as stated.
MPORTANT	w II	296 SIGNATURE AND FITLE	OF CERTIFIER	5/	0.02100	~			29c. LICENSE NUN	MBER		29d, DATE	pranyo in	Rough, Day, Year)
ME ME	10 B	-/on	11	Deve	207	P			D185	229		14	1/7/	43
	- [	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	E OF DEATH	H (ITEM 279(Typ	e, Print)		1 -	1	,	1	1/	1. 0.0
	ļ	JON D	Lowe	EYMP,	600	KIDE	551	JF	TVE. SI	tel	6, 1	tnn	ofle	Eu, M
		31. DATE FILED (Month, Day,		32. REGISTRA				/					/	21401
L		APR - 9 1	993	Julia David	cor-10	indelle								[0]
				-	_									DHMH-16 Rev 1/89

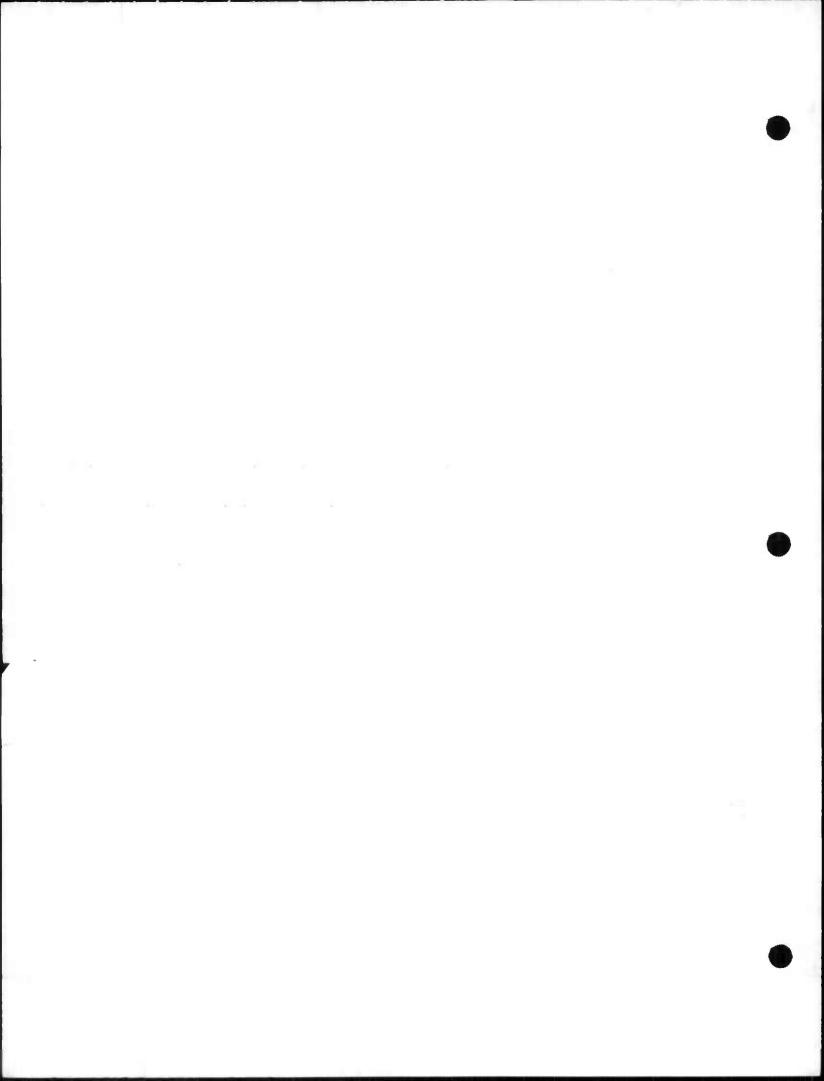


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	1 - FOR STATE REGISTRAR	STATE OF F	MARYLAND / CE		RTMENT				MENTA	L HYGIE!	-		
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE	OF DEATN	DAY	VF 10	3. TIME OF DEATH
			CHASE						MONT 0 4			YEAR	1650 M
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. lest		IF UNDER	1 YEAR	IF UNDER	24 HRS.		OF BIRTH h, Day, Year)			PLACE (State or Foreign
	216-84-3493	1 M 2 XF	30	YRS.					ر	1-9-6			
œ	9e. FACILITY NAME (If not institution, give st			9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH								EATH	
5	1816 Henneman	Avenue			Ba.	Ltin	nore						
RE	10s. STATE 10b. COUNTY	1			Y, TOWN C								10d. INSIDE CITY LIMITS?
BY FUNERAL DIRECTOR	M; D			R	alt	mor	`e						1X YES 2 NO
RAL	10e. STREET AND NUMBER	C 4				101.	ZIP CODE					EN OF W	VHAT COUNTRY?
NE NE	926 N. Chapel						212				USA		
5	11. MARITAL STATUS  1 X Never Married 2 Married	FORCES? 1	T EVER IN U.S. ARI		13.	WAS DEC	encent o	F HISPAN n, Mexical	n, Puerto	(? (Specify Ye Rican, etc.)	s or No-	Black	— American Indian, t, White, etc.
	3 Widowed 4 Divorced	IF YES, GIVE W	MAR OR DATES		1	YES	2/\_/NO	Specify				Speci	Black
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a, DEG	CEDENT'S	USUAL OC	CCUPATIO	N of workin		166	KIND OF BU	ISINESS/INDL		
LEI	Elementary/Secondary (0-12)	College (1-4 or 5	*)		work done (		SE OF WORKER	g					
MP	12th		Un	ıemp	loye	e d			$\perp$		-		
	17. FATNER'S NAME (First, Middle, Last)									Middle, Melder Chas	,		
BE	David Gamble  190. INFORMANT'S NAME (Type/Print)		104	MAIL INC	ADDRESS	(Conset to					e vn, State, Zip		
2	Michelle Chase												21223
	20e. METNOD OF DISPOSITION		20b. PLACEA	NDDATE	OF DISPOS	ITION/Na	me of		DAT		CATION — C		
	X☐XBuriel 2 ☐ Cremation 3 ☐ Remo		Cometery, crem	"Mem	or 1	al P	ark		1		ndall	-	V-7.00
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE				_	D ADDRES		CILITY				,
	Synette	55	force	0	WI	1 C.	MA	RCH	F.H	1./11	01 E	. N(	ORTH AVE.
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,											Approximate		
	IMMEDIATE CAUSE (Final			0									Interval Batween Onset and Death
	disease or condition a. Strangulation  out to (or as a consequence or):												
		OUE TO	(OR AS A CONSEO	VENCE O	F):								
Ö	Sequentially list conditions, if any, leading to immediate	DUE 10	(OR AS A CONSEQ	UENCE O	F):								
CAT	cause. Enter UNDERLYING CAUSE (Disease or Injury	c											
TH	that initiated events resulting in death) LAST	OUE TO	(OR AS A CONSEO	UENCE O	F):					-			
CERTIFICATION	Teaching in death) CAST	d											
	PART il. Other algnificant condition	a contributing to	death but not re	eauiting	in the un	derlying	cauae g	lven in i	Part I.	24s. WAS AF		24b.	WERE AUTOPSY FINDINGS
3										PERFO			AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ME									_	-			1 XYES 2 NO
ÿ													
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER		ACE OF O						
1YS	1. YES 2 NO 27. MANNER OF OEATH	1 🗆 Inpetient 2 🗆	ER/Outpatient 3	DOA 28b, TIM	4 🗆 Nurs	ing Nome		sidence				_	lwelling
	1 Natural 5 Pending	(Month, D			JURY M		RK? ES 2	NO	28d. UE;	CRIBE NOW	INJURY OCCI	URED	
ЭВУ	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE O	F INJURY — At hon	me, farm, i	street, fact		14.4	,	281. LOC	ATION (Street	and Number o	or Rural A	oute Number,
TE	4 Nomicide determined	Dunany,	etc. (Specify)						City	or Town, State	)		
COMPLETED	29e. CERTIFIER (Check only 1 CERTIFYING PHYSIC	CIAN: To the best of	my knowledge, des	ath occurre	ed at the ti	me, dete	and place,	and due	to the cau	ree(e) end ma	nner es atate	d.	
NO.	One) 2 MEDICAL EXAMINE												and manner as stated.
ш	296. SIGNATURE AND TITLE OF CERTIFIER	1 1	2.				29c. LICE	NSE NUM	BER		29d. DATE	SIGNEO	(Month, Day, Year)
TO B	Venne	in & Cl	rut ans	,			0.0	C.M.	Ε.		04	05	1993
	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUS	SE OF DEATH (FTEM	1 27) (Type,	, Print)								
	31. DATE FILED (Month, Day, Year)	1 an ansolerm	11	1 Pr	enn	Str	eet.	Ba	ilti	more	Mar	yla	nd21201
	APR 09 1993	325HEGISTHA	SIGNATURE	dell									

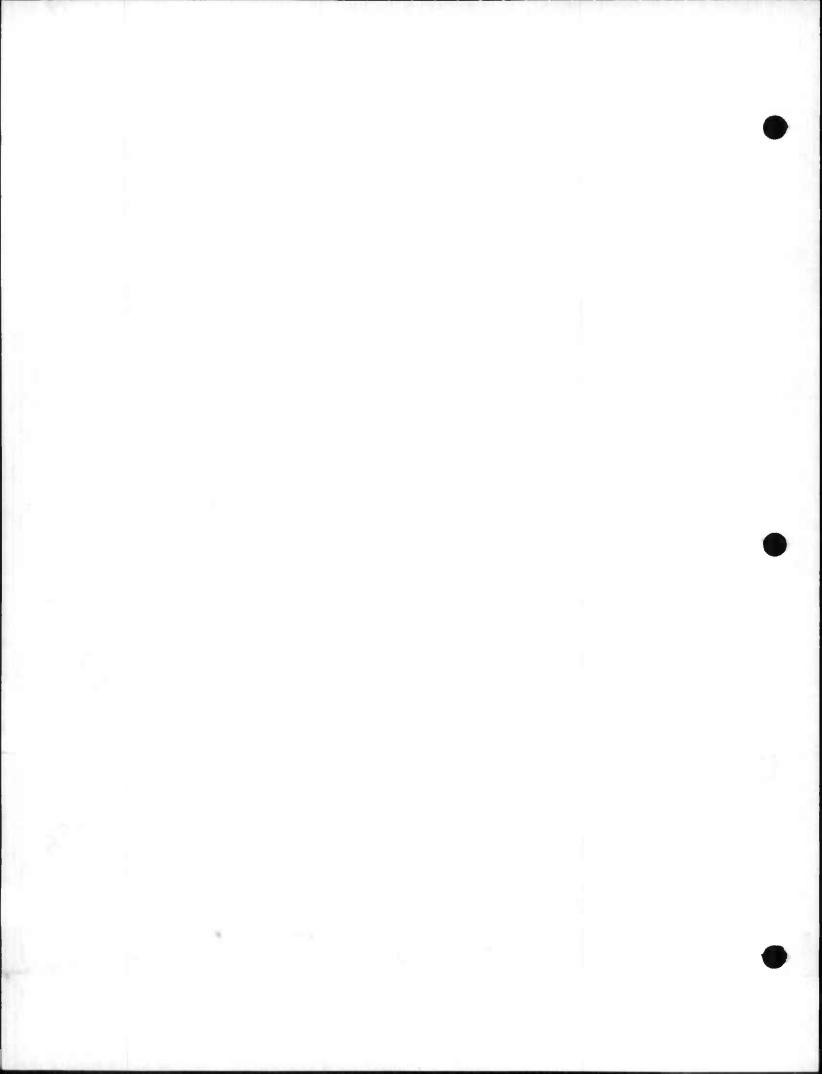


	1 - STATE REGISTRAR	STATE OF MARYL			OF HEAL		MENTAL HYGIEN	_			
	1. DECEDENT'S NAME (First, Middle, Last) WYETTE (Wuatt) (Wayet	Ţ. tė)	CLYBUR	N			2. DATE OF DEATH O 4 0 7	** 1993	SAR 3. TIME OF DEATH 11:24 A M		
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday	) IF UNDER	1 YEAR IF L	NOER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8.	BIRTHPLACE (State or Foreign Country)		
	251-03-8803	1 💢 M 2 🗆 F	73 YRS.	- 1	3.033		1-23-20		5.0.		
OR O	90. FACILITY NAME (It not institution, give st Sinclair 2123 ST.CLAIR	LANE			TOWN OR LO		EATH	9c. COUNTY	OF DEATH		
<u>يَّا</u>	RESIDENCE OF DECEDENT  10e. STATE  10b. COUNTY		10.0		OR LOCATION						
DIRECTOR	MD				more				10d. INSIDE CITY LIMITS?		
IA I	10a. STREET AND NUMBER				10f. ZIP	CODE		10g. CITIZEI	N DF WHAT COUNTRY?		
FUNERAL	2123 Sinclair				212				JSA		
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 TYES IF YES, GIVE WAR DR D	2 Y MO		WAS DECENDE If yea, specify ( I \( \text{YES 2 }\)	Suben, Mexico	NIC DRIGIN? (Specify Yes an, Puerto Rican, atc.) fy:	or No — 14	Black, White, etc.  Specify Black		
	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DECEDENT	'S USUAL O	CCUPATION	orkina	16b. KIND OF BU	SINESS/INDUS	TRY		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)		use retired.)	during most of v	o tong	Getzes	Meat	+ Co		
OM	17. FATHER'S NAME (First, Middle, Last)		GN.	LINDER		OTHER'S NA	ME (First, Middle, Maiden				
6 111	Frank Clyburn						Frazier	Juliane)			
TO BE	19e. INFORMANT'S NAME (Type/Print)				(Street end Nu	mber or Rural	Route Number, City or Tow		<sup>(de)</sup> 21212		
	Henry Clyburn					Lan	e Apt.1/B				
	1 N Buriel 2 Cremation 3 Remo	ival from State	netery, crematory of	other place) Met	h. Ch	. Cei	1		or Town, State		
	21. SIGNATURE OF FUNERAL SERVICE LICE		1	_	NAME AND AD				,		
	WM C. MARCH F.H./1101 E. NORTH AVE.										
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or reepiratory errest,										
m, me	IMMEDIATE CAUSE (Final	Arteriosc			rdiov	ascul	ar Disea	se	Intervel Between Onset and Death		
Z	ē.	DOE TO (DR AS A	CONSEDUENCE	DF):							
CERTIFICATION	Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (DR AS A	CONSEQUENCE	DF):							
FIG	CAUSE (Disease or injury that initiated events	DUE TO (DR AS A	CONSEDUENCE	OF):							
E	resulting in death) LAST	J									
	PART II. Other significent conditions	contributing to death b	ut not resulting	in the un	derlying ceu	se given in	Part I. 24e. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS		
SICAL							PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE		
MEDIC							INQU		DF DEATH? 1 YES 2 NO		
Ä											
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL: 1   Inputient 2   ER/Outp		OTHER	l:	F OEATH (Ch					
H	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TI	ME OF	28c. INJURY A		8 Other (Specify) 28d. DESCRIBE HOW II	NJURY OCCUR	EO		
ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	10	IJURY M	WORK?	2 🗌 NO					
									Rural Route Number,		
COMPLETED	29. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.  2 MEDICAL EXAMINER: Do like basis of axamination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated.										
8	296. SIGNATURE AND TITLE OF CERTURER	fall 7	7			. C . M .			GNEO (Month, Day, Year) 08-1.993		
5	MARIO F. GOL	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Typ)		Stree	t, Ba	ltimore,	Mary	land 21201		
	31. DATE FILED (Month, Bay, Yeer)	32. REGISTRAR'S SIGN	ATURE								
	APR 09 1993 ina Davidson-Rande										



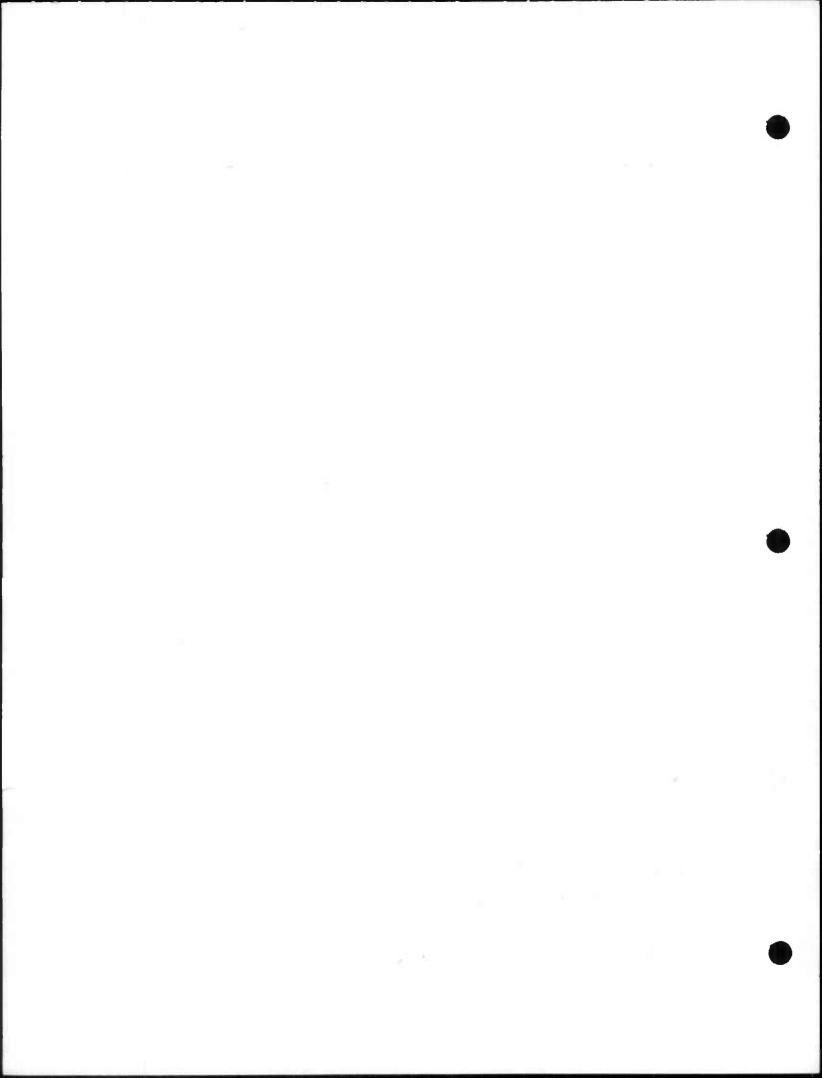
DHMH-16 Rev 1/89

		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF H	HEALTH AND ME	NTAL HYGIENE REG. NO.				
		1. DECEDENT'S NAME (First, Middle, Last) GREGORY CART					DATE OF DEATH DAY	YEAR 3. 1	TIME OF DEATH		
		4. SOCIAL SECURITY NUMBER	T	(In yrs. lest birthday)	IF UNDER I YEAR	IF UNDER 24 HRS. 7.	4 - 5 - 93 DATE OF BIRTH	6. BIRTHPLA	MCE (State or Foreign		
9	3	216-78-3945	1 💢 M 2 🗆 F	33 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) 9-21-59	8. BIRTHPLA Country)	D		
3 should	Œ	90. FACILITY NAME (If not institution, give Francis Scott	The state of the s		96. CITY, TOWN O	OR LOCATION OF DEATH	9c.	COUNTY OF DEATH	н		
2	CTOR	RESIDENCE OF DECEDENT									
Pages	DIRE	MD 100. STATE 10b. COUNT	Y		TOWN OR LOCAL			2-57	d. INSIDE CITY		
sermit.		10e. STREET AND NUMBER		Dal	timore	1. ZIP CODE	10g	. CITIZEN OF WHAT	YES 2 NO		
an. ransit (	FUNERAL	6801 McClean				21234	l	JSA			
21215-0020 al or attending physician. for use as the buriat-transit permit. Pages 1.	B≺	11. MARITAL STATUS  1 Never Married 2 Merried  3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 X YES IF YES, GIVE WAR OR DO	2 NO	If yes, sp	CENDENT OF HISPANIC ( lectify Cuben, Mexican, Pi 3 2 X NO Specify:	ORIGIN? (Specify Yes or No uerto Rican, etc.)	14. RACE — American Indian, Black, White, etc. Specify B 1 a C K			
215 attenduse as	ETED	15. DECEDENT'S EDU (Specify only highest grad	JCATION e completed)	16a. DECEDENT'S L	ork done during me	ON pet of working	16b. KIND OF BUSINESS				
	PLE	Elementary/Secondary (0-12) 12th	College (1-4 or 5+)	Disab							
YLAND 2 by the hospital be detached for	COMPL	17. FATHER'S NAME (First, Middle, Last)		01345	Ted	18. MOTHER'S NAME (	First, Middle, Maiden Surner	me)			
2 2 2 K	BE	Eugene A. Cartwright Sr. Earlene Hall  190. INFORMANT'S NAME (Type/Print)  190. MAILING ADDRESS (Street and Number Of Part Bruse Mumber City or Favor State To Contain									
MARY retained b 5 should	2	Earlene Cartwright 6801 McClean Blvd/Baltimore MD 212									
RE, nay be r, page		20a, METHOD OF DISPOSITION 1   Buriel 2   Cremation 3   Ren	20b	PLACEANDDATEO	F DISPOSITION (Na	ame of	DATE 200 LOCATIO	N - City or Town	State		
MOR age 6 ma director, p		4 Donallon 5 Other (Specify)	Ğ	arrison	Fores	t Va Cem	etery Owi	ngs Mi	11s, MD		
BALTIMORE, after death. Page 6 may be by the funeral director, page moval.		· Vanessi	Coal			MARCH	т F.H./1101	E. NO	RTH AVE.		
urs a		23. PART I. Enter the disesses, or shock, or heert failure.	complications that caused List only one cause on e	the death. Do no	ot antar the mo	de of dying, such se	cardiac or respirator	y srrest,	Approximate Interval Between		
fille fon,		IMMEDIATE CAUSE (Finel disease or condition resulting in death)	Hypot	CNSI UN					Onset and Death  3 hrs		
executed within and completely o bunial, crematic antificial matter event, it	z							ļ	24 hrs		
BOX 68: cate be execute hysician and c prior to buria	ATIO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING									
O. BC ertificate ing physic giene pri other tr	FIC	CAUSE (Disease or Injury that Initiated events	OUE TO (DR AS A	CONSEQUENCE DE	:		1-Longs				
T + 2 =	CERTIFICATION	resulting in death) LAST	a AEDS					years			
DS, F the death the atter d Mental injury, o	AL C	PART II. Other significant condition	ns contributing to death b	ut not resulting in	the underlyin	g ceuse given in Par			RE AUTOPSY FINDINGS		
OR OR	MEDIC/	large rutal draw	by of pus,			Mulcur	PERFORMED?	CO1	MILABLE PRIOR TO MPLETION OF CAUSE DEATH?		
RECOF v requires that been signed to t. of Health at shows any		bipolar disorder	, anemia,	nentrop	enla,		. 1	1 [	YES 2 NO		
AL law las b Dept.	IAN	25. WAS CASE REFERRED TO MEDICAL	chronic reno	el insuffic		LACE OF DEATH (Check of	only one)				
TA S	PHYSICIAN:	EXAMINER?  1 YES 2 NO	HOSPITAL: 1 Inpatient 2 - ER/Outp		OTHER:	ne 5 🗆 Residence S 🗆					
Z Z	ВУ РН	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	M t .	PRK? YES 2 ND	d. DESCRIBE HOW INJURY	OCCURED			
TISIC TTENDI TOR: A after d		3 Suicide 6 Could not be 4 Homicide determined	28a. PLACE OF INJURY building, etc. (Spec	— At home, farm, st	reet, factory, offic	e 28	I. LOCATION (Street and Nu City or Town, State)	imber or Flural Route	Number,		
DIV SPITAL OR A INERAL DIREC ITHIN 72 HOURS INT: If Item	COMPLETED		ER: On the beat of my know						d manner as stated,		
TO THE HOSPITAL OF TO THE FUNERAL DE filed within 72 ho	TO BE	29b. SIGNATURE AND TITLE OF CERTIFIE	Jun MS	J306		29c. LICENSE NUMBER	29d.	DATE SIGNED (Mor	nth, Day, Year)		
		30. NAME AND ADDRESS OF PERSON WI				/ -	/ / /				
		Adam 1. Lot 31. DATE FILED (Month, Day, Year)	17 M D, J 32. REGISTRAR'S SIGN		Kins Ito	spitel, Ba	(Homore, M)	0			
		APR 09 1993	Julia Davidson	-Randoll							



00050

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM	MENT OF H	EALTH AND		YGIENE EG. NO.	ככט	30		
	1. DECEDENT'S NAME (First, Middle, Last)	VARD C				2. DATE OF D	DEATN	3. TIME C	OF DEATH		
	GEORGE EVA		OULTER	- WARRA A MEAN	T	-			6 P M		
	249-24-1587	1 1 M 2 F 6	-	HTHE DAYS	HOURS MIN.	7. DATE OF B	9-1924	8. BIRTHPLACE (St. Country)			
	9a. FACILITY NAME (If not inetitution, give s		_	b. CITY, TOWN (	TY, TOWN OR LOCATION OF DEATH  9-29-1924   South Carola  9c. County of Death						
DIRECTOR	Francis Scott K	ey Medical Ce	nter	BAI	ALTIMORE CITY						
INE.	10e. STATE 10b. COUNT		10c. CITY, T	OWN OR LOCAT				10d. INSIDE CI LIMITS?			
	Maryland 100. STREET AND NUMBER	Baltimore			Dund	lalk			2 (XNO		
FUNERAL	510 Bayside Dr	ino		101	. ZIP CODE	21222		en of what coul nited St			
Š	11. MARITAL STATUS	12. WAS DECEDENT EVER IN		13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No. 14. RACE — America							
BY F	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 X YES IF YES, GIVE WAR OR DAT		If yes, sp	ecify Cuben, Mexica 2 NO Specif	an, Puerto Rican.		Specify:	ic.		
	15. DECEDENT'S EDU	<u> </u>	Whi								
	(Specify only highest grade	completed)	(Give kind of work life. Do NOT use re	done durina mo		16b. KINI	D OF BUSINESS/INDU	STRY			
4	8th Grade	College (1-4 or 5+)	Ga	шаел		Ros	thlehem S	tool Can	110		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					AME (First, Middle	, Maiden Surname)	LEEL CON	J		
BE (	B. H. Coulter						e Brewer				
6	190. INFORMANT'S NAME (Type/Print) Linda L. Baker						ity or Town, State, Zip C				
		205 (	PLACE AND DATE OF C				Maryland				
	20g, METNOD OF DISPOSITION  1 🖾 Burial 2 🗆 Cremation 3 🗆 Rem  4 🗆 Donation 5 🗆 Other (Specify)	oval from State camer	Oak Lawn	Cenete			Baltim		uland		
ı	21. SIGNATURE OF FUNERACISERVICE LIC	ENSEE		22. NAME AN	ID ADDRESS OF FA	CILITY 1	tome of Di	d ai D la	7		
	157	1		7922	Wiso Au	onlo 1	Dundalk,	unauce, Marulana	10C.		
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such se cardiac or respiratory strest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Arteriosclerotic Cardiovascular Disease										
z			CONSEQUENCE OF):								
CERTIFICATION	Sequantially list conditions, if any, lasding to immediate	DUE TO (OR AS A C	CONSEQUENCE OF):								
S	CAUSE (Disease or Injury	C. DUE TO OR AS A	CONSEQUENCE OF):								
Ē	that initiated events resulting in death) LAST		CONSECUENCE OF):					i			
	DART II Other stantilless and little	1.									
SAL	PART II. Other significant condition	s contributing to death but	t not resulting in t	he undariying	cause given in	Part I. 24a.	WAS AN AUTOPSY PERFORMED?		PRIOR TO		
E						1 1	YES 2 NO	OF DEATH			
Σ.						—   Tr	NQUIRY	1 YES	2 NO		
XA!	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			26. PL	ACE OF DEATH (Ch	eck only one)		1			
PHYSICIAN: MEDIC	1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Output		THER:  Nursing Home	5 Residence	8 Other (Spe	ocify)				
	27. MANNER OF DEATH  1 Natural 5 Pending	26e. DATE OF INJURY (Month, Day, Year)	28b. TIME O	WO	URY AT RK? 'ES 2 NO	28d. DEŞCRIB	E NOW INJURY OCCU	IRED			
BÝ	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY -	At home, farm, stree				(Street end Number of	r Rural Route Numbe	Br.		
	4 Nomicide determined	building, atc. (Specify	y)			City or Tow	vn, State)				
COMPLETED		CIAN: To the best of my knowled							ner ee stated.		
шШ	29h. SIGNATURE AND TITLE OF CERTIFIER				29c, LICENSE NUN			SIGNED (Month, De			
10 B	with y	telle A	1		OCM	E	<b>▶</b> 4	7	1993		
F	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DEAT	IN (ITEM 27) (Type, Prin	nt)							
	INDEX OF GOL	VE JURUM )1	11 Penn	Stree	et, Bal	timore	e, Maryl	and 2	1201		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNAT	W								



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

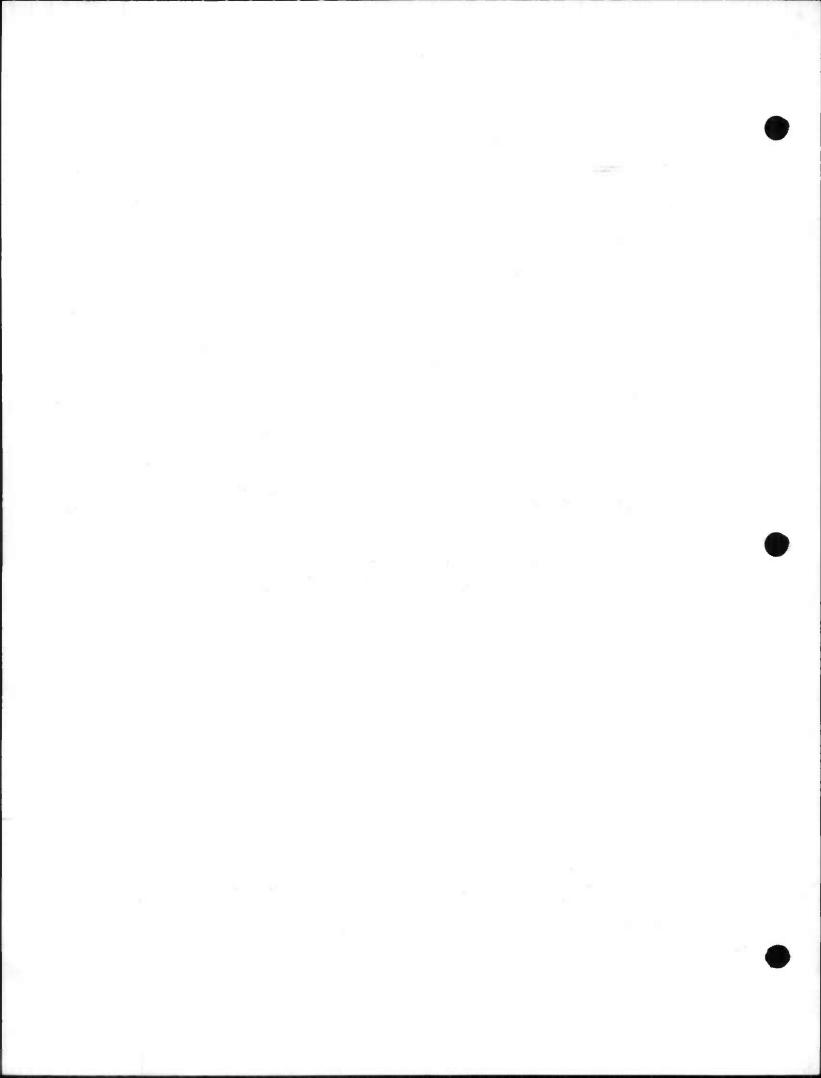
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

ITEMS: 4. PER F.	H. G-698	4/13/93	t.t							9	3	09959
1 - FOR STATE REGISTRAR	STATE OF I	MARYLAND / CE	DEPAR	ICAT	T OF I	HEALTH DEA	AND	MENTAL HYGI REG.				
1. DECEDENT'S NAME (First, Middle, Last)  June Ann Lewis	Cortese							2. DATE OF DEATH MONTH April	DAY 5	199	YEAR	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER 953 1 185-28-9501	5. SEX	6. AGE (In yrs. lest	t birthday) YRS.	IF UNDER	DAYS	HOURS	R 24 HRS.	7. DATE OF BIRTH (Month, Day, Year June 10	7	33	Count	HPLACE (State or Fore
9s. FACILITY NAME (If not institution, give street and number)  1000 Harris Mill Road RESIDENCE OF DECEDENT				9b. CITY, TOWN OR LOCATION OF DEATH 9c. (					c. COUN	COUNTY OF DEATH Baltimore		
10s. STATE 10b. COUNT	timore	•	10c. CIT	y, town	or Loca							10d. INSIDE CITY LIMITS? 1 YES 2 X N
100. STREET AND NUMBER 1000 Harris Mill	Road				10	7. ZIP COD			10	-	ZEN OF V	WHAT COUNTRY?
11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES?	NT EVER IN U.S. ARI I YES 2 X N MAR OR DATES		- 1	If yes, s		an, Mexica	NIC ORIGIN? (Specify an, Puarto Rican, atc.) fy:		No-	14. RACI Black Spec	E — American Indian k, White, atc.

- 1	Jule Will Pears Colfese				APTIL	5 19	93	M		
	0531	yrs. lest birthday)	IF UNDER 1 YEA		7. DATE OF BIRT (Month, Day, Ye	H Ner)	8. BIRTHPL Country)	ACE (State or Foreign		
	185-28- <b>950</b> 1 1□ M 2 🛣 59	YRS.						sylvania		
or	9s. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOV	N OR LOCATION OF DE	EATH	9c. COU	NTY OF DEA	тн		
DIRECTOR	1000 Harris Mill Road		Par Par	Parkton Baltimore						
E.	10e. STATE 10b. COUNTY	10c. CITY,	CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?			
ō	Maryland Baltimore	Parkt	on			1 YES 2 X NO				
₹	10e, STREET AND NUMBER				101. ZIP CODE			AT COUNTRY?		
FUNERAL	1000 Harris Mill Road			21120		U	SA			
E	11. MARITAL STATUS  1 ☐ Never Married 2 ☑ Married FORCES? 1 ☐ YES		13. WAS	DECENDENT OF HISPAI apecify Cuban, Mexica	NIC ORIGIN? (Speci	fy Yes or No—	14. RACE Black, V	- American Indian, Vhita, atc.		
B	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DA	TES		res 2 X NO Specif		37	Specify:	White		
	15. DECEDENT'S EDUCATION	16a. DECEDENT'S U	ISUAL OCCUP	ATION	16b, KIND O	F BUSINESS/INC	DUSTRY			
(Specify only highest grade completed)  (Give kind of work done during most of working life. Do NOT use retired.)  (Give kind of work one during most of working life. Do NOT use retired.)  Baltimore County										
15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  4  16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  Baltimore County  Health Departs  17. FATHER'S NAME (First, Middle, Last)  18. MOTHER'S NAME (First, Middle, Maiden Surname)								epartment		
ŏ	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NA	ME (First, Middle, M	alden Surname)		-		
BE (										
2	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING	ADDRESS (Stre	et and Number or Rural i	Route Number, City o	v Town, State, Zip	Code)			
-	Saverio A. Cortese	1000	Harris	Mill Road	l, Parkt	on, MD	21120			
- 1	20a. METHOD OF DISPOSITION  197 Burlel 2 Cremetton 3 Removal from State  20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, creme									
	The state of the s									
- 1	21. SIGNATURE OF FUNERAL SERVICE LICENSES (LICENSES)  22. NAME AND ADDRESS OF FACILITY  Lemmon-Mitchell-Wiedefeld. Inc.									
	Bryan W. Clary		10	W. Padonia	Rd. T	imonium	n. MD	21093		
	23. PART I. Enter the diseases, or complications that caused shock, or heert failure. List only one cause on se	tha death. Do no	ot enter the	mode of dying, suc	h aa cardlec or	respiratory an	rest,	Approximate		
	IMMEDIATE CAUSE (Final									
1	disease or condition a. METASTARE	D 15 845	of 3	He Lu	4.765 Smos.					
	disease or condition resulting in death)  a. METASTATIC  DUE TO (OR AS A  Sequentially, lies conditions	CONSEQUENCE OF)	11.1		d					
N	Sequentially list conditions, on Malignant	TIBROUS CONSEQUENCE OF	Hist	iogtome	14161	7				
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	CONSEQUENCE OF)	*							
윤	CAUSE (Disease or Injury C.	CONSEQUENCE OF)	:							
E	resulting in death) LAST									
AN: MEDICAL	PART II. Other eignificant conditions contributing to death but	t not resulting in	the underly	ring cause given in		REPORMED?		ERE AUTOPSY FINDINGS WILABLE PRIOR TO		
ă					1 🗆 Y	ES 2 NO		OMPLETION OF CAUSE F DEATH?		
Σ					_		1	☐ YES 2 ☐ NO		
Ä	25. WAS CASE REFERRED TO MEDICAL									
	EXAMINER? HOSPITAL:		OTHER:	PLACE OF DEATH (Ch	eck only one)					
PHYSICI	1 VES 2 NO 1 Inpetient 2 ER/Outpa 27. MANNER OF DEATH 28s. DATE OF INJURY	tiant 3 DOA 28b. TIME		INJURY AT						
	1 Natural 5 Pending (Month, Day, Year)	INJU	RY	WORK7	28d. DESCRIBE H	IOW INJURY OC	COMED			
À	2 Accident Investigation 3 Suicide & Could and be 26s. PLACE OF INJURY	- At home, farm, atr			28f. LOCATION (S	treat and Number	r or Bural Bout	n Number		
	4 Homicide determined building, stc. (Special	y)			City or Town,	State)	07 1107 17 17 1001	o realizado,		
COMPLETED	29s. CERTIFIER (Check only   CERTIFYING PHYSICIAN: To the best of my knowle	doe death economic	at the Her-	late and electrical dis	A- Ab					
Ř	(Check only one)  2 MEDICAL EXAMINER: On the besis of axamination							od manner as etered		
- 11	290 SHOWATURE AND TITLE OF CERTIFIER		, -,-,-							
ᆱ	to X to MO			D-43		29d. DAT	E SIGNED (M	orith, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEA	TH (ITEM 27) (7000 5	Print)	7 45	100		JUV	)		
Î				p_1	one Im	21205	C 2	5040		
	Trank Frassita, M.D. OVI	n. caror	THE 2	t., Baltim	ore, m	Z1ZUD	oulte	DZ43		

32. APGISTRAR'S SHINATURE 31. DATE FILED (Month, Day, Year)
APR 09 1993



THE DIRECTOR AND CONTINUED THE CONTINUED BY THE WINDOWS THE CONTINUES THE CONTINUES THE CONTINUES OF THE CON
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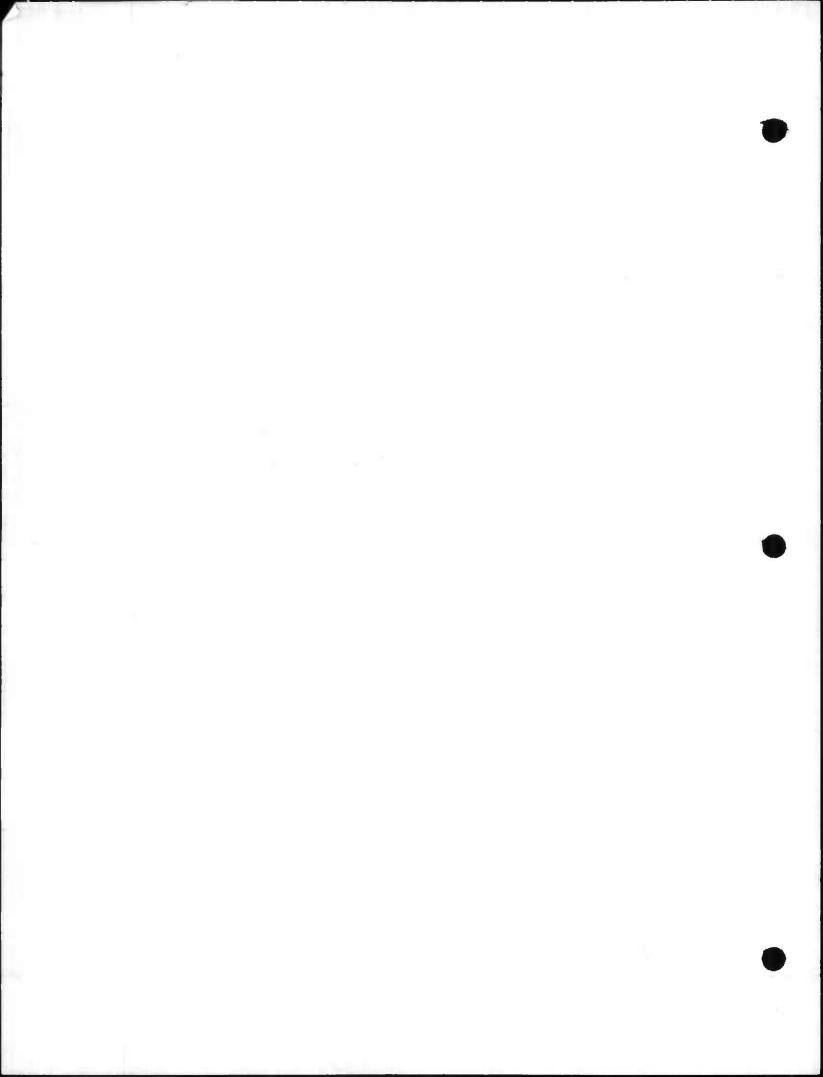
	FOR	STATE OF N	MARYLAND	/ DEPAI	RTMEN	T OF I	HEALTH ANI	D MEN	ITAL HYGIEN		93	09960	
	REGISTRAR		С	ERTIF	ICAT	E OF	DEATH		REG. NO.				
1	1. DECEDENT'S NAME (First, Middle, Last) Thelma			DIE	TRIC	H.		.34	PATE OF DEATH DATE OF DATE OF	1993	YEAR 3.	12:30 ÄM	
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. le		IF UNDE	R 1 YEAR	IF UNDER 24 HR		ATE OF BIRTH Month, Day, Year)		8. BIRTHPLA Country)	MCE (State or Foreign	
	214-26-6126	1 M 2 XF	89	9 YRS.	MONTHS	DAYS	HOURS MIN		Dec.10,1903 M			MAryland	
-	So. FACILITY NAME (If not institution, give s				9b. CIT		OR LOCATION OF	F DEATH			TY OF DEAT	OF DEATH	
0	FRanklin Square Hospital Rossville  RESIDENCE OF DECEDENT  100. STATE  100. COUNTY  Md.  Baltimore  FRanklin Square Hospital  Rossville  Rossville  Residence OF Decedent  100. CITY, TOWN OF LOCATION  ESSEX									Bal	ltimor	e	
E E	10a. STATE 10b. COUNT	Υ		10c, CI	ry. TOWN	OR LOCA	TION					d. INSIDE CITY	
E I	Md.	Baltimo	re	1111	.,		Ssex				LIMITS?		
										T COUNTRY?			
FUNERAL	333 Upperlanding Road 21221								USA				
3	11. MARITAL STATUS	12. WAS DECEDEN		RMED	13	WAS DEC	ENDENT OF HIS	PANIC OF	RIGIN? (Specify Yes	or No	14 BACE	American Indian.	
	1 Never Married 2 Married	FORCES? 1	YES 2	MO	"	If yes, sp	ecify Cuban, Me:	xican, Pu	erio Rican, etc.)	or No.	Black, W	Thite, etc.	
B	3 🔀 Widowed 4 🗌 Divorced	la Tes, Give w	BAT ON DATES			1 L TES	2 □ <sup>A</sup> NO Sp	ecity:			Specify: Whi	te	
8	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  16a. DECEDENT'S USUAL OCCUPATION (She kind of work done during most of working												
	Elementary/Secondary (0-12) College (1-4 or 5 +) ##e. Do NOT use retired.)												
MP	12th Housewife												
100	17. FATHER'S NAME (First, Middle, Last)  18. MOTHER'S NAME (First, Middle, Maiden Surname)												
BE													
0	196. INFORMANT'S NAME (Type/Print)  196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
-	Robert Hardingham 333 Upperlanding Road Baltimore Md. 21221								221				
	20a. METHOD OF DISPOSITION 1 Gremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. PLACE AND DATE DISPOSITION (Name of Completery Crematory of Other Charactery Hill Cemetery 4/9/93  20c. LOCATION - City or Town, State BAltimore Md.												
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE						22. NAME AND ADDRESS OF FACILITY  Connelly Funeral Home of Essex 300MaceAve.  21221						
	23 PART I. Enter the disease f, Dr complications that caused the deeth. Do not anter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Septic Snock  But to (or as a consequence of):												
		Pneumor		EOUENCE O	PF):							1	
RTIFICATION	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):												
FIC	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	cOUE TO	(DR AS A CONSE	EQUENCE O	F):				_				
CERI	resulting in death) LAST	d											
4	PART II. Other significant condition			resulting	in the u	nderlyin	g ceuse given	in Part	i. 24a. WAS AN PERFOR			RE AUTOPSY FINDINGS	
음	Severe Coronary	Artery L	Jisease						1 TES 2		co	MPLETION OF CAUSE DEATH?	
: MEDICAL			_							X		YES 2 ND	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL					26 PI	LACE DF DEATH	(Chaok on	1				
S	EXAMINER? 1 TYES 2 TO NO	HOSPITAL:	EB/Outrestant	2 🗆 204	OTHE	R:							
¥	27. MANNER OF DEATH	28a. DATE OF		28b. TIA			ie 5 🗆 Residen	1	Other (Specify) DESCRIBE HOW II	I III III OO	YIRED		
	1 X Natural 5 Pending	(Month, D		IN.	JURY	WC	YES 2 NO	200.	DESCRIBE NOW II	WORT OCC	CONED		
ED BY	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE O building,	F INJURY — At h	ome, farm,	street, fac				LOCATION (Street a City or Town, State)	nd Number	or Rural Route	e Number,	
LETE	4 Homicide determined												
COMPLET	(Check only one)  1 CERTIFYING PHYSI One)  2 MEDICAL EXAMINE											od manner as stated.	
BE C	296. SIGNATURE AND TITLE OF CERTIFIED						29c. LICENSE	NUMBER		29d. DATE	SIGNED (Ma	onth, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WH		SE OF DEATH AT	FM 27) /5/04	Drint)						( - / .	- 93	

.D., 9000 Franklin Square Drive, Baltimore, MD 21237

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

M

Jonathan Simons.
31. DATE FILED (Month, Day, Year)
APR - 9 1993



BALTIMORE, MARYLAND 21215-0020

VITAL RECORDS, P.O. BOX 68760,

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HOSPITAL	UNERAL	within 72
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2	2	2
	TO THE HOSPITAL ON A TEMPINA PHYSIC	HOSPITAL ON PTENDING PHYS FUNERAL DIRECTOR CONTRACTS

31. DATE FILED (Month, Dey, Year)

APR 09 1993

	IIEM: 1/	, 19a, PER	F.H. G-	698 4/13/93	t.t	000	20061			
	1 - FOR STATE REGISTRAR		LAND / DEPART CERTIFIC	MENT OF HEALTH AND CATE OF DEATH	MENTAL HYGIEN REG. NO		19961			
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH	AY YEAR	3. TIME OF DEATH			
il	MAGNOLIA F	URMAN			April 01	0.00	06:50 A M			
	4. SOCIAL SECURITY NUMBER			IF UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	B. BIRTHE	PLACE (State or Foreign			
1 1	213-09-1189	1 🗆 M 2 🛴 F	88 YRS.	IONTHS DAYS HOURS MIN.	(Month, Day, Year) 9-13-0	8. BIRTHE Country	VA			
_	te. FACILITY NAME (If not institution, give	street end number)	1	9b. CITY, TOWN OR LOCATION OF E	EATH	9c. COUNTY OF DE				
DIRECTOR	THE UNION MEMO	RIAL HOSPITA	L _	BALTIMORE CIT	Υ					
	10a. STATE 10b. COUNT	ry	10c. CITY,	TOWN OR LOCATION		T	10d. INSIDE CITY			
临	MD		Balt	timore			LIMITS?			
A	10e. STREET AND NUMBER			10f. ZIP CODE		18g. CITIZEN OF W	HAT COUNTRY?			
띨	The street and number  2810 Harford Rd.  101. ZIP CODE  109. CITIZEN OF WHAT COUNTRY  2810 Harford Rd.  11. MARITAL STATUS  11. MARITAL STATUS  12. WAS DECEDENT EVER IN U.S. ARMED  13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. RACE — American in Hyes, specify Cuben, Mexican, Puerto Rican, etc.)  11. Marital Status  12. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. RACE — American in Hyes, specify Cuben, Mexican, Puerto Rican, etc.)									
5	11. MARITAL STATUS  12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. RACE — American in If yes, specify Cuban, Maxican, Puerlo Rican, etc.)  14. RACE — American in If yes, specify Cuban, Maxican, Puerlo Rican, etc.)									
To 3/1 Wildowed 4 □ Divorced IF YES, GIVE WAR OR DATES 1 □ YES 2 1 NO Specify: Specify: Specify:										
	15. DECEDENT'S EDUCATION 18. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY									
	Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT use	retired.)						
N N	(Specify only highest grade completed)  Elementary/Secondary (0-12)  12th  Restaurant  18. MOTHER'S NAME (First, Middle, Last)  Luthow From Secondary (1-4 or 5 +)  No or Secondary (1-4 or 5 +)  Restaurant  18. MOTHER'S NAME (First, Middle, Maiden Surname)									
	19. MECOMANT'S NAME (Revision)									
4	Wilson Factor Jr. 405 Joppa Farm Rd. / Joppa , MD 21085									
20a, METHOD OF DISPOSITION  20b. PLACE AND DATE OF DISPOSITION (Name of Complete Com										
	4 Donation 5 Other (Specify) Arbutus Memorial Park Arbutus, MD  21. SIGNATURE OF FUNERAL SERVICE LICENSES									
WM C. MARCH F.H./1101 E. NORTH										
23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
	IMMEDIATE CAUSE (Final	Myoc		1 infarel	LON	. /_	Onset and Death			
	disease or condition resulting in death)	. Ho has	unliegig	1 conclind trust	wer acri	dent.				
		DUE TO (OR A	A CONSEDUENCE OF	emblic T	0/					
NO N	Sequentially list conditions,	DUE TO (OR AS	A CONSEDUENCE OF:	orary and	ery aux	ease	2			
AT	If any, leading to immediate cause. Enter UNDERLYING	Ahral	trale con	-la	7	(Adl)				
Ĕ	CAUSE (Disease or injury that initiated events	DUE TO (DR AS	A CONSEQUENCE OF):			1000				
CERTIFICATION	resulting in death) LAST	d				1 2				
	PART II. Other significant condition	ns contributing to death	but not resulting in	the underlying cause given in	Part t. 24s. WAS AN		WERE AUTOPSY FINDINGS			
MEDICA					PERFOR	CHO CO	MAILABLE PRIOR TO COMPLETION OF CAUSE			
ME							OF DEATH?			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSFITAL:		26. PLACE OF DEATH (CO	heck only one)					
IYS	1 VES 2 NO 27. MANNER OF DEATH	1 Inpetient 2 ER/O	utpatient 3 DOA 4	☐ Nursing Home 5 ☐ Residence						
	1 Natural 5 Pending	(Month, Day, Year		OF 28c. INJURY AT WORK?  M 1 YES 2 NO	28d. DEŞCRIBE HOW I	NJURY OCCURED				
ВУ	2 Accident Investigation 3 Suicide 6 Could not be	26e. PLACE OF INJU	RY — At home, ferm, str		281. LOCATION (Street 1	and Number or Flural Ro	oute Number,			
ETED	4 Homicide 6 Could not be determined	building, etc. (S	овспу)		City or Town, State)					
PE	29a. CERTIFIER 1 CERTIFYING PHYS	SICIAN: To the best of my kn	owledge, death occurred	at the ilms, date and place, and du	e to the cause(s) and mar	nner as stated.				
COMPL				In my opinion, death occured at the			and manner as stated,			
ш	296. SIGNATURE AND TITLE OF CERTIFIE	R		29c. LICENSE NU	MBER	29d. DATE SIGNED	Month, Day, Year)			
TO B	( Cell MI)					► 4/06 (	93			
	30 NAME AND ADDRESS OF PERSON W	201 E. Um	DEATH (ITEM 27) (Type, P	D Ball	imore, h	un 212	18			
	AN LIO. 1 MA)				1	010	. ~			

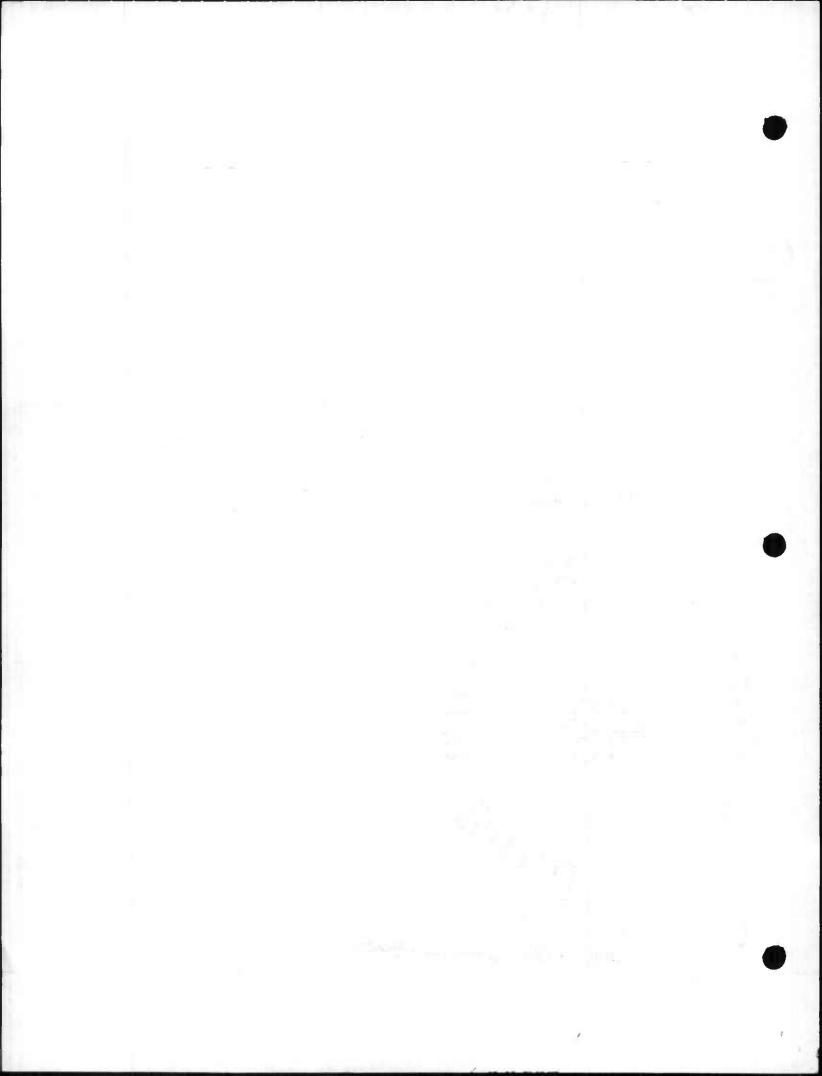
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REGISTRAR		CERTIFIC	CATE OF D	EATH	REG. NO.		
1. DECEDENT'S NAME (First, Middle, Las	" Paul Hu	ghes	Forbes		2. DATE OF DEATH MONTH DAY	Q YEAR	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER 213-34-4984	5. SEX 6. AGE (in			UNDER 24 HRS, DURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRT	HPLACE (State or Foreig
9s. FACILITY NAME (If not institution, give			Ph. CITY, TOWN OR L	OCATION OF DE	8-26-193	9c. COUNTY OF	rginia
	·		Towa				timore
10a. STATE 10b. COUN	пту	10c. CITY,	TOWN OR LOCATION				10d, INSIDE CITY
St. Joseph Hosp.  RESIDENCE OF DECEDENT  100. STATE  Maryland  Maryland	Baltimore			Dunda	lk		LIMITS?
10e. STREET AND NUMBER			10f. Zif	CODE		10g. CITIZEN OF	WHAT COUNTRY?
10e. STREET AND NUMBER  31 02 Lynch Road  11. Marital Status	12. WAS DECEDENT EVER IN 1	LC ABMED	140 1100 0505110	212			ted States
3 Widowed 4 Divorced	FORCES? 1 YES	2 X NO	If yes, specify		C ORIGIN? (Specify Yes o , Puerto Rican, etc.)	Spe	E — American Indian, ik, White, etc. city: White
15. DECEDENT'S EC	DUCATION de completed)	IGA. DECEDENT'S U	k done during most of	working	16b. KIND OF BUSI	NESS/INDUSTRY	
Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT use	·				
Elementary/Secondary (0-12) 12th Grade 17. FATHER'S NAME (First, Middle, Last)		Plum		MOTHER'S NAM	E (First, Middle, Maiden S	umamal	
Wallace Guy For	rbes				Pauline S		
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DDRESS (Street and I		oute Number, City or Town,		
Mary Shipplett		7819	St. Clare	Lane	Baltimore	Marula	nd 2122
20a. METHOD OF DISPOSITION 1 ◯ Burist 2 □ Cremation 3 □ Rs		ery, crematory or other	ir placel				
4 Donation 5 Other (Specify)		ak Lawn	Cemetery	4/9/	93 Bak	timore,	Maryland
1			Duda	-Ruck F	uneral Hon	ne of Du	ndalk. In
23 PART I. Enter the diseases, o			7922	Wise A	ve. Dunda	U.k. Mar	uland 212
IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	a. DUE TO (OR AS A C	EUSI O	HEAD V SIVOSIJ		HLURE		Onset and MONTH YR YR
PART II. Other significant conditions of the con	ons contributing to death but	t not resulting in	the underlying ca	iuse given in F	24a. WAS AN A PERFORM  1 YES 2	IED?	b. WERE AUTOPSY FIN MAILABLE PRIOR TO COMPLETION OF CA OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH			28 PLACE	OF DEATH (Chec	ok ontrone)		
EXAMINER?	HOSPITAL:		OTHER:	ART A SECTION A			
27. MANNER OF DEATH	28e. OATE OF INJURY (Month, Day, Year)	28b. TIME INJUI	OF 28c. INJURY		28d. OESCRIBE HOW IN.	JURY OCCUREO	
2 Accident Investigation	1		M 1 TES	2 NO			
3 Suicide 6 Could not b 4 Homicide datsmined	28e. PLACE OF INJURY — building, etc. (Specify	- At home, farm, str	eet, factory, office		28f. LOCATION (Street an City or Town, State)	d Number or Rural	Route Number,
U .	SICIAN: To the best of my knowled	doe doub	of the time data			- 115.712.4	
E I	SICIAN: To the best of my knowled NER: On the basis of examination s						s) and manner as =t=
1 20h SIGMATINE AND TITLE OF CERTIF		۸		c. LICENSE NUM		29d. DATE SIGNE	
30. NAME AND ADDRESS OF PERSON V	Mason U	(T) (Type, F		D 173	47	▶ 4-	6-93
STAVAV 9 31. DATE FILED (Month, Day, Year)	1A50 M	DIRE DE		IEARC	DRIT	dusu	MD 212
APR = 9	1993 Julie De	vidour-Alans	ARC)				

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,



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	1.	D	ECEDE	NT	S N
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Pages 1, 2, 3 should

TO BE COMPLETED BY FUNERAL DIRECTOR

REGISTRAR  CERTIFICATE OF DEATH  1. DECEDENT'S NAME (First, Middle, Last)  2. DATE OF DEATH  3. TIME OF S									
	HTASC								
Elaine Elizabeth Gephardt April 8, 1993	on M								
4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birthday)   IF UNDER 1 YEAR   IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State	or Foreign								
215_69_2057 1 M 2 LF 72 YRS MONTHS DAYS HOURS MIN. (Month, Day, Year) Country)									
9a. FACILITY NAME (If not institution, give street and number)  9b. CITY, TOWN OR LOCATION OF DEATH  9c. COUNTY OF DEATH	a								
216 Hambarra Zan									
RESIDENCE OF DECEDENT ESSEX Baltimore	Baltimore								
10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE									
Md. Baltimore Essex									
10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY?									
216 Homberg Ave. 21221 USA									
11. MARITAL STATUS  12. WAS DECEDENT EVER IN U.S. ARMED  13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No.— 14. RACE — American Inc.									
1 Never Married 2 Married FORCES? 1 YES 2 MO If yes, specify Cuben, Maxican, Puarto Rican, etc.)  Black, Whita, etc.									
3 Wildowed 4 Divorced IF YES, GIVE WARF ON DATES 1 YES 2 NO Specify: Specify: White									
15. DECEDENT'S EDUCATION 168. DECEDENT'S USUAL OCCUPATION 189. KIND OF BUSINESS/INDUSTRY									
(Specify only highest grade completed)  (Give kind of work done during most of working life. Do NOT use retired.)									
8th Housewife	201								
17. FATNER'S NAME (First, Middle, Last)  18. MOTNER'S NAME (First, Middle, Meiden Surname)									
John was a second secon									
Westey Gillesdie Rose Sakowski  198. INFORMANT'S NAME (Typer/Print)  199. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
George Gephardt 216 Homberg Ave. Baltimore Md. 21221  20a. METNOD OF DISPOSITION  20b. PLACE AND DATE OF DISPOSITION / Name of OATE 20c. LOCATION — City of Town, State									
1 Durisi 2 Cremetion 3 Removal from State cometery, cremetory or other place)									
21/SIGNATURE OF FUNERAL SERVICE LICENSEE  Oak Lawn Cemetery 4/12/93  Baltimore Md.									
ConnellyFuneralHome 300MaceAve. 212	21								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,									
	and Desth								
	and Dodge								
disease or condition resulting in death)  s. ProSable Myocardial Infarction  Due TO (OR AS A CONSEQUENCE OF!)									
disease or condition resulting in death)  s. Progable Myoccardial Infarction  Due TO (OR AS A CONSEQUENCE OF!)	- 1								
Sequentially list conditions,									
If sny, leading to immediate cause. Enter UNDERLYING									
CAUSE (Disease or Injury that Initiated events OUE TO (OR AS A CONSEQUENCE OF):									
resulting in death) LAST									
0.									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED?  AMILABLE PR									
Ceretyovescular disease COMPLETION	AVAILABLE PRIOR TO COMPLETION OF CAUSE								
OF DEATH?	□ NO.								
25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one)									
EXAMINER? HOSPITAL: OTHER:									
1   Inpetient 2   ER/Outpetient 3   DOA   4   Nursing Nome 5   Residence 6   Other (Specify)  27. MANNER OF DEATH   28s. DATE OF INJURY   28b. TIME OF   28c. INJURY AT   28d. DESCRIBE HOW INJURY OCCURED									
(Month, Day, Year) INJURY WORK?									
2 Accident Investigation M 1 YES 2 NO									
3 Suicide 8 Could not be 4 Nomicide 6etermined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number. City or Town, State)									
29s. CERTIFIER (Check only 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and menner as stated.									
one) 2 MEDICAL EXAMINER: On the beele of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner.	sa stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Y	bar)								
N. Sarou MD D19133 + 4/8/9	3								
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)									
31. DATE FILEO (Month. Day Year) 32. BEGISTRAB'S SIGNATURE	31. DATE FILEO (Month, Day, Year) 32. REGISTRAR'S SIGNATURE								
31. DATE FILEO (Month, Day, Year)  32. REGISTRAR'S SIGNATURE  APR = 9 1993  Author Devides Parket									

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or among any TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detacted for use at the befunding the filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DNMN-16 Rev 1/89

use as the burial-transit permit. Pages 1, 2, 3 should

detached for

page 5 should be

notified at

pe

3 Suicide

4 Homicide

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The same of the sa	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,	hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.	item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must
		č	2

93 09964 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 04 /1993 Grigor 08 Emma 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign DAYS 1 🗌 M 2 🙀 F 052-09-4684 99 02/02/94 New York 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Frederick Villa Nursing Center Catonsville Baltimore 10e. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Baltimore Arbutus 1 TES 2 NO FUNERAL 10a. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY 5230 Benson Avenue 21227 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO 14. RACE — American Indian, Black. White, etc. 1 Never Married 2 Merried BY IF YES, GIVE WAR OR OATES Specify: white 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EOUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor Manufacturing 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) George Michael Pistor Margaret Hill BE 190. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Jane Leonard 5230 Benson Avenue, Arbutus, MD 21227 20s. METHOD OF DISPOSITION
1 Burlel 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State cometery, cremetory or other piece)
Meadowridge Memorial Park 4 Donation 5 Other (Specify) 4/10 Dorsey, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Ambrose Funeral Home, Inc. Combuse 1328 Sulphur Spring Rd. Arbutus, MD 21227 23. PART I. Enter the diseeses, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heert fellure. List only one ceuse on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF) MEDICAL CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in deeth) LAST PART II. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TES 250 NO 1 TYES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF OEATH (Check only one) HOSPITAL:
1 | Inpetient 2 | ER/Outpatient 3 | DOA OTHER: 1 TES 2 THO 4 KNursing Ho ne 5 - Residence S - Other (Specify) 27. MANNER OF DEATH 25e. OATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 K Natural 5 Pending 1 YES 2 NO BY 2 Accident

29e. CERTIFIER

(Chack note)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(e) end mariner as steted. (Check only one) 2 MEDICAL EXAMINER: On the basis of exa ination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(s) and manner se stated.

29c. JACENSE NUMBER

28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify)

3 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Dr. White Frederick Road, Catonsville, MD 21228 31. DATE FILED (Month, Day, Year)

0 9 1993

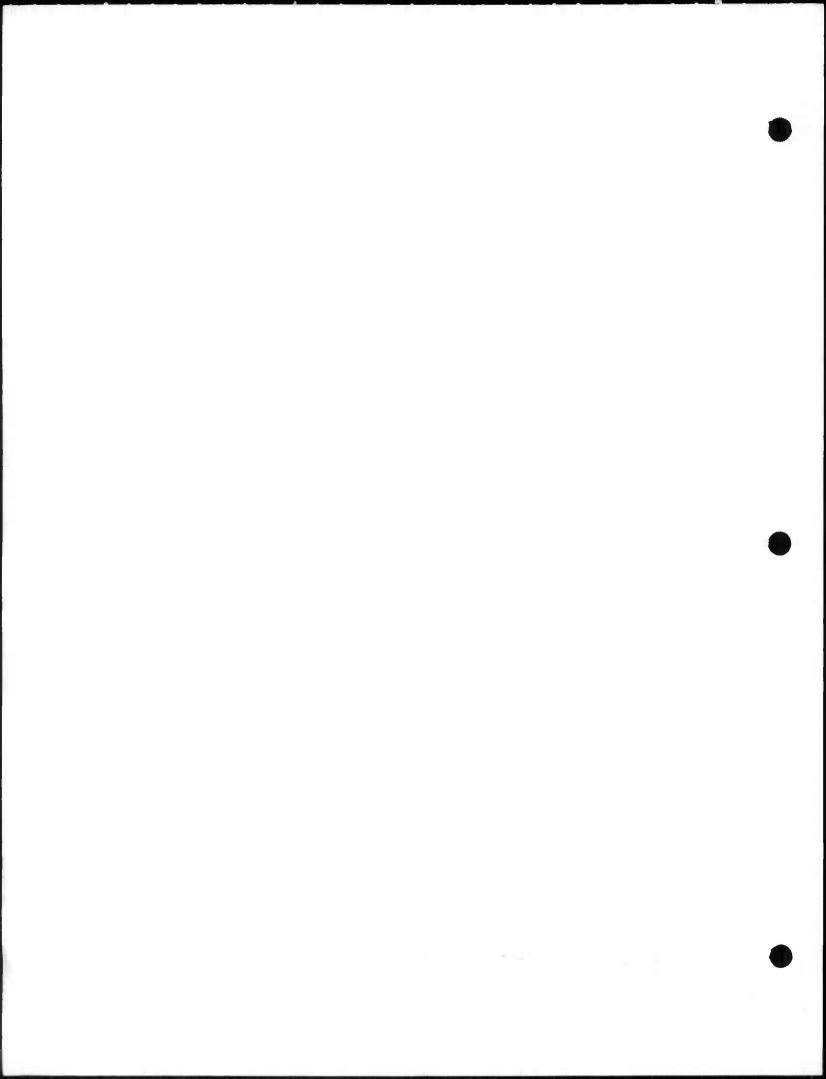
S Could not be

296. SIGNATURE AND TITLE OF CERTIFIER

32 REGISTRAR'S SIGNATURE

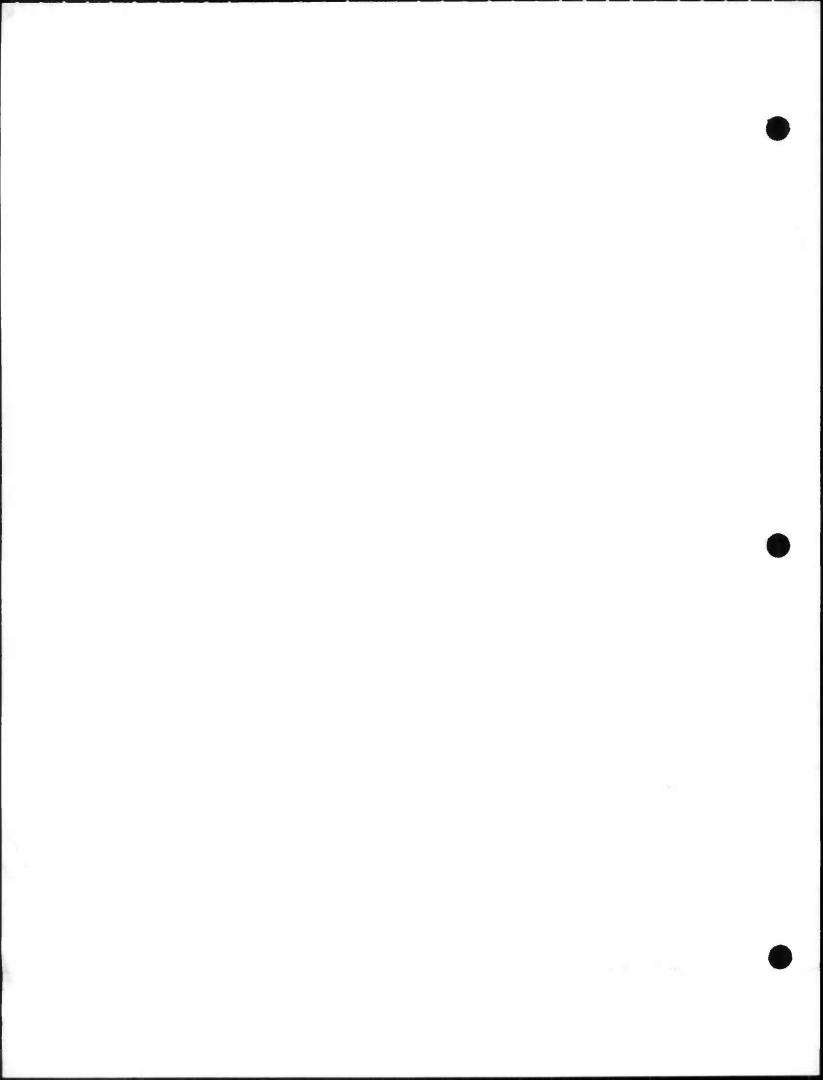
Qay, Year)

291. LOCATION (Street end Number or Rural Route Number, City or Town, State)



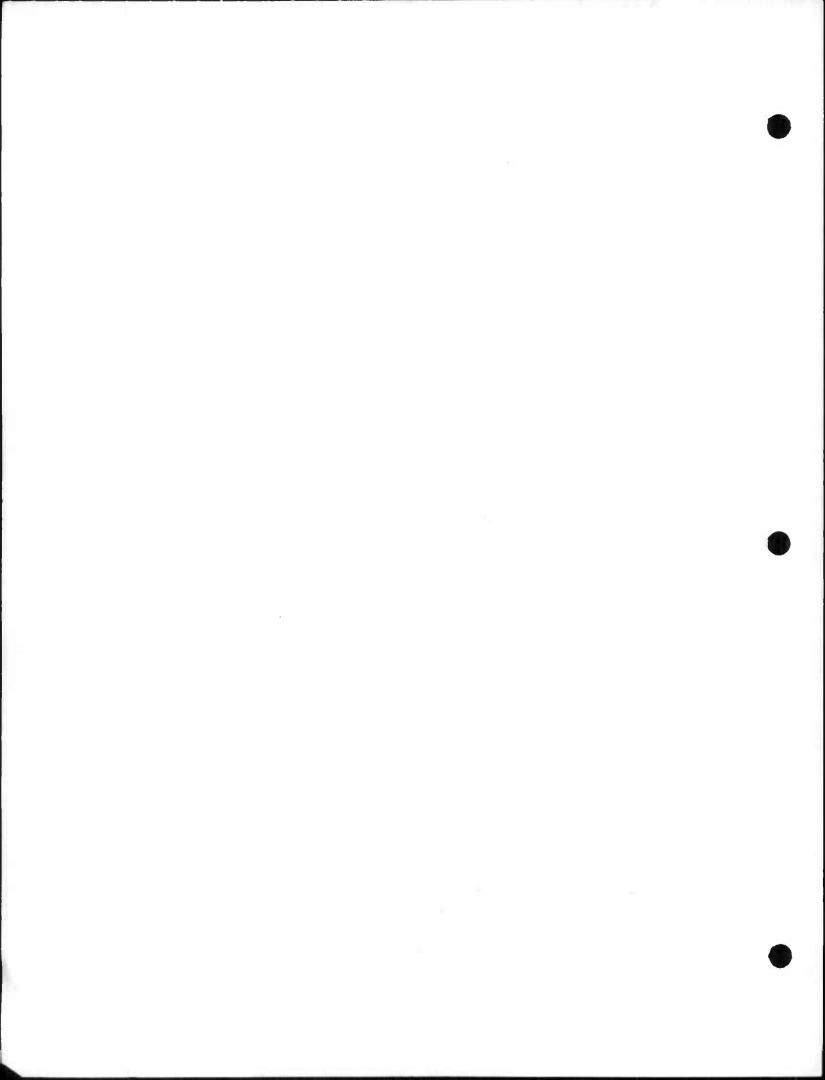
9	
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit per military and Merital Havington promotion or removal	tuneral director, page 5 should be detached for use as the burial-transment permit in per 1, 2, 3 should
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	examiner must be notified at once.
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	COMPANY AND AND AND AND AND AND AND AND AND AND

	REGISTRAR		CERTIF	ICATE C	F DEATH	F	REG. NO.					
	1. DECEDENT'S NAME (First, Middle, Lest)					2. DATE OF	_			3 TIM	E OF DEA	TH
	An	na Marr	Gerst	MITO 10		MONTH	DA	1	YEAR			
	4. SOCIAL SECURITY NUMBER 5. SEX		rs. last birthday)			Apri			993		:45	
		(iii )		IF UNDER 1 YEA		7. DATE OF (Month, D	ay, Year)		a. BIRTH	PLACE	(State or F	-oreign
		12 XF 82	YRS.	20-10-10		05/0	4/10		Ma	ry1	and	
	9e. FACILITY NAME (If not institution, give street and	number)		9b. CITY, TOW	N OR LOCATION OF D	EATH		9c. COUN	TY OF D	EATH		
K	2716 Bauernwood Avenue 21234 Baltimore City											
RESIDENCE OF DECEDENT												
2	10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LO	CATION						SIDE CIT	Υ
ā	Maryland -				Ralt	imore					MITS? 'ES 2 [	NO.
7	10e. STREET AND NUMBER		1	T	101. ZIP CODE	I more		10g. CITIZ	ZEN DE V	Δ.		,
2	2716 Bauernwood	A 17 0 m 11 0		1		234		rog. Offia			ONTHIT	
Z		S DECEDENT EVER IN U.							US			
BY FUNERAL	1 Never Married 2 Married FOR	RCES? 1 YES 2	NO NO	13. WAS I	DECENDENT OF HISPAI specify Cuban, Mexica	NIC ORIGIN? (S en, Puerto Rice	pecify Yee n. etc.)	or No—	14. RACE Black	- Ame	ricen Ind	len,
≥	3 Widowed 4 Divorced	ES, GIVE WAR OR DATE	S		rES 2 NO Specif				Speci			
										W	<u>hit</u>	e
2	15. DECEDENT'S EDUCATION (Specify only highest grade complete	d) 16	e. DECEDENT'S (Give kind of v	vork done during	ATION most of working	16b. Kir	ND OF BUS	INESS/IND	USTRY			
		e (1-4 or 5 +)	ille. Do NOT us	4.4.4.								
§ I	125-	+	Scho	ol Tea	acher	Pu	blic	Scl	hoo	1 S	vst	em
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA							
BE (	John Ger	stmyer			Caro	line	"IIn	know	to.	Roc	ord	C 11
	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Stre	et and Number or Rural	Route Number,	City or Town	State. Zip	Code)	пет	.OLU	5
임	Franklin W. Asche	emeier			rnwood A					2	123	/1
	20e. METHOD OF DISPOSITION	20h PI	ACE AND DATE	DE DISPOSITION	Mama of	DATE	200 100	ATION C	M T.			+
	1 Buriel 2 Cremation 3 Removal from 4 Donation 5 Other (Specify)	n State cemeter	y, cramatory or o	thar placa)	ry, Inc.	1.16	D =	T + d =	ny or 10	wii, Stati	MD	
		1100	10 01	ana u	AND ADDRESS OF FA	470	De	11111	HOLE	٥, .	עוצ	
	21. SIGNATURE OF FUNDRAL SERVICE LIGENSEE	for the			nation S		37 Of	- MA		Inc		
	George E. Mad	cNabb		299	Frederi	ck Po	y OI	lalto	, ,	ND .	212	2.8
	23. PART I. Enter the diseasea, or complica	ations thet caused th	e deeth. Do r	ot enter the	mode of dying, auc	h aa cardiac	or respir	atory erre	ent.		pproxim	
	shock, or heart failure. List only	y one cause on each	line.		,			,	,	le le	iterval B	Between
	IMMEDIATE CAUSE (Final disease or condition	1111	1.	/							,	d Death
H	resulting in death)	Metastad DUE TO (OR AS A CO	10 00	lon .	concer				-	V	4 mo	millo
		DUE TO (OR AS A CO	NSEQUENCE OF	<b>ጉ</b> :								
CERTIFICATION	Sequentielly list conditions, b.	PUE TO 100 10 1 00										
F	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CO	NSECUENCE OF	-):								
일	CAUSE (Diseese or Injury C	DUE TO (OR AS A CO	MOTOLISMOT OF							_		
Ē	that initiated events resulting in death) LAST	DOE TO (OH AS A CO	MSECUENCE OF	-):								
與Ⅱ	d									-		
	PART II. Other algnificant conditions contri	buting to death but r	not resulting i	n the underly	ing cause given in	Part I 24	. WAS AN A	UJTOPSV	245	WEDE A	UTOPSY F	MONOS
DICAL							PERFOR		240.	AVAILAB	LE PRIOR	OT 9
						10	YES 2	NO		OF DEA	ETION OF	CAUSE
Σ						_				1 🗌 YE	S 2 🗌	NO
ž l												
5 1	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				PLACE OF DEATH (Ch	eck only one)						
BY PHYSICIAN: ME	nose	ortlent 2 - ER/Outpatie	nt 3 🗆 DOA	OTHER:	ome 5 Reeldence	6 Other (Sc	necify)					
Ē	27. MANNER OF DEATH 280	. DATE OF INJURY	28b. TIM	E OF 28c.	INJURY AT	28d. DESCRI		JURY OCC	URED			
7	1 Netural 5 Pending	(Month, Day, Year)	INJ		WORK? YES 2 NO							
	2 Accident Investigation 3 Suicide & Could not be 26	. PLACE OF INJURY -	At home, farm, a			28f. LOCATIO	N (Street or	od Mumbae	as Oural D	house Africa	nho.	
	4 Homicide 6 Could not be determined	building, atc. (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To	wn, Stele)	TO THUMBON C	a nurei n	oute Nan	iowi,	
COMPLETED	29e. CERTIFIER					<u> </u>						
€	(Check only 1 CERTIFYING PHYSICIAN: To											
ō I	2 MEDICAL EXAMINER: On the	basis of examination en	d/or investigation	n, in my opinior	, death occured at the	time, date end	place, end	due to the	ceuse(s)	end ma	inner ee s	stated.
	296. BIGHATURE AND TITLE OF CENTIFIER	111.			294. LICENSE NUN	MBER	T	29d. DATE	SIGNED	(Month.	Day, Yearl	
8	18 But	Clay 11	al		294. LICENSE NUN	587						
유	30. NAME AND ADDRESS OF PERSON WHO COMPL			Printi		t			)4/C	10/5	, )	
1		. 1			1 0 1	107	D : -					
	Paul Chang, M.D.  31. DATE FILED (Morith, Day, Year)	5601 Loc	n kave	su RIA	a. Suite	e 10/	RAT	to.,	MD	21	239	)
	32.	NEGISTRAN'S SIGNATUL	nc.									



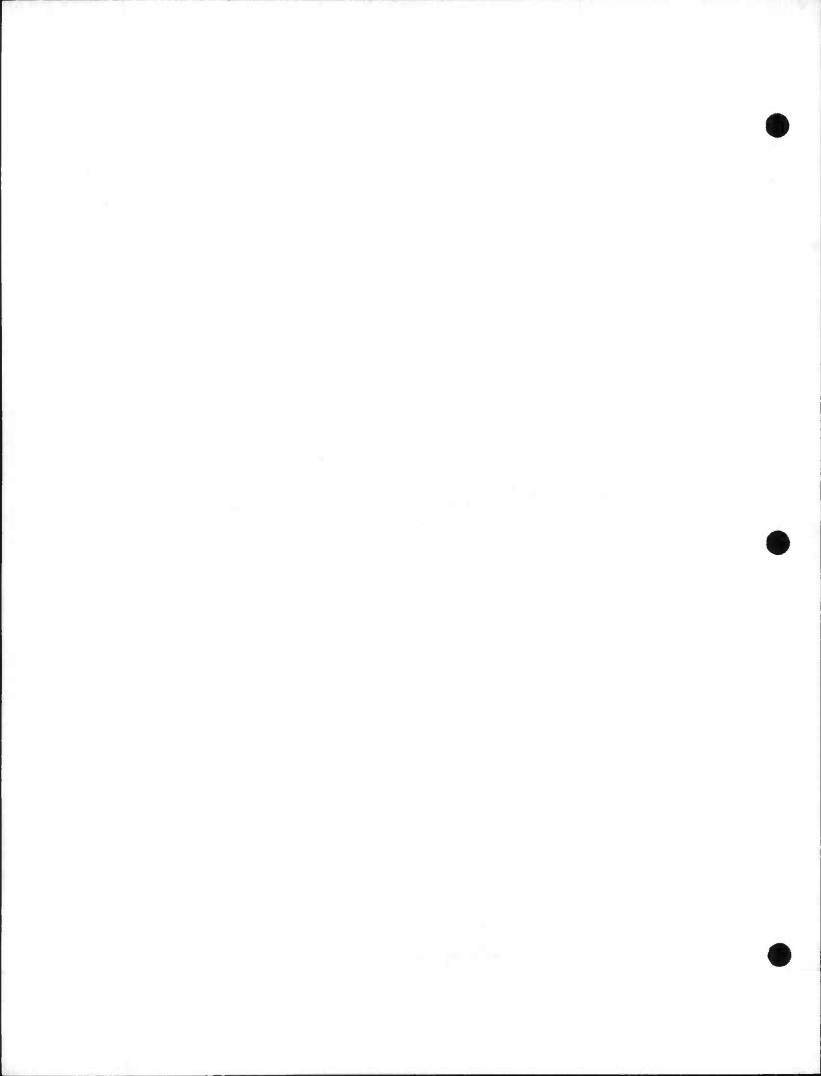
BALTIMORE, MARYLAND 21215-0020	The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician.	The speed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be controlled for use as the burial-transit permit. Pages 1, 2, 3 should be controlled from the prior to burial, cremation, or removal	medical examiner must be notified at once.
DIVISION DEVITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING FINE CONTINUES IN THE CONTINUES THAT THE CONTINUES BE EXECUTED WITHIN 24	TO THE FUNERAL INHECTION AND three has been signed by the attending physician and completely filled in by the fi be filed within 72 went to be the property of Health and Mental Hydiene prior to burial, cremation, or removal	IMPORTANT: If Item 28 is marked of Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	п. К. р.											C	3	09966
_	1 - FOR STATE REGISTRAR		STATE OF M		/ DEPART						GIEN 6. NO.		J	0 ) ) 0 0
	1. DECEDENT'S NAME (First,     4. SOCIAL SECURITY NUMB	Jew		Hym	10 M	/			Ö	NATE OF DEA	06		9 3	3. TIME OF DEATH  10:20 A M
	212-38-30	22	1 🗆 M 2 💢 F	8. AGE (In )rs. In	,, l-	IF UNDER 1 YO		F UNDER 24 H OURS MI		7. DATE OF BIRTH (Month, Day, Year) 8. BIRTI Count 6-11-62			HPLACE (State or Foreign ry) MD	
e B	98. FACILITY NAME (If not integrated as a second se	AYETT		г.		BAL		ORE		7.	9c. COUNTY OF DEATH			
<u> </u>	RESIDENCE OF DEC	10b. COUNTY	,		40. 0174	TOWN OR L								
- DIRECTOR	MD		•			BALTIMORE					10d. INSIDE CITY LIMITS?  XXYES 2 \( \text{NO} \) NO			
₹.	10e. STREET AND NUMBER						101. ZI	P CODE				10g. CIT	ZEN OF	WHAT COUNTRY?
W W	2333 E. F	AYET						2120					.S.	Α.
FUNERAL	11. MARITAL STATUS  [文文 Never Married 2 ]	Married	12. WAS DECEDENT FORCES? 1	EVER IN U.S. AI	RMED NO	13. WAS	DECENI	DENT OF HI	SPANIC OF	RIGIN? (Spec erto Rican, a	ffy Yes	or No-	14. RACI	E — American Indian, k, White, etc.
Divorced  IF YES, GIVE WAR OR DATES  1 YES 2/T-NO Specify:  Specify:  D.T. A.														
H	15. DECI (Specify only	EDENT'S EDUC highest grade	CATION completed)	18a. Di	ECEDENT'S U Give kind of we b. Do NOT use	JSUAL OCCU	PATION	f working		16b. KIND (	F BUS	INESS/INC	USTRY	
COMPLETED	Elementary/Secondary (0-	-12)	College (1-4 or 5+)											
₹	10th				UNEME	PLOYE	-							
	17. FATHER'S NAME (First, Mi						10			irst, Middle, M		Sumame)		
BE	ROY HYMAN									RIFF				
5	ALICE PUR		CE.		6. MAJLING / 2110									1231
	20a, METHOD OF DISPOSITE	ON	-		AND DATE OF							CATION	_	
	Buriel 2 Cremetion 5 Other	n 3 □ Ramo (Specify)	oval from State	cemetery, cri	ematory or oth	er place)			1					
	21. SIONATURE OF TUNERAL	SERVICE LIC	ENSEE A					ADDRESS O	F FACILITY	,	SAL	71. 1. 141.	URE	, MD
	► ( )( ) d	IMA	1/2	1		WM.	C.M	IARCE	I F.1	н./13	101	E.	NOI	RTH AVE.
	23. PART I. Enter the di- shock, or he iMMEDIATE CAUSE (Fin disease or condition resulting in death)	ert Isliure, I	. MULTIF	csused the doe on each line	AB !							ratory sri	est,	Approximate interval Between Onset and Death
CERTIFICATION	Sequentially list condition if any, leading to immediate. Enter UNDERLYII CAUSE (Disease or injust that initiated events resulting in death) LAST	liate NG ny	bOUE TO (C	OR AS A CONSE	OUENCE OF)									
	PART II. Other significs:	nt conditions	s contributing to d	eeth but not	resulting in	the under	lying c	euse giver	n in Part I	l. 24a. W		AUTOPSY	24b	. WERE AUTOPSY FINDINGS
PHYSICIAN: MEDICAL						91				1-72 Y	RFOR			AMAILABLE PRIOR TO COMPLETION DF CAUSE
WEI										X				DF DEATH? 1 XYES 2 □ NO
ż														
¥	25. WAS CASE REFERRED TO EXAMINER?	MEOICAL					8. PLACI	OF DEATH	(Check on	ly one)				
SIC	1 YES 2 □ NO		HOSPITAL: 1   Inpatient 2	ER/Outpetient 3	DOA	OTHER:	Home :	Reside	nca 8 🗆 (	Other (Specifi	y)			
E	27. MANNER OF DEATH		28a. DATE OF II (Month, Day	NJURY	286. TIME		: INJURY WORK?	AT	7 -	DESCRIBE I		JURY OC	CURED	
ВУ		Pending nvestigation	04/06	93	102	0A 1		2 X NO	SU	JBJEC	Т	CUT	AND	STABBED
ED	3 Suicide 8 0	Could not be	28e. PLACE OF building, et	INJURY — At he	ome, farm, st	reet, fectory,	office		281.	LOCATION (S City or Town,	Stotel	nd Number	or Rural I	Route Number,
	4 Nomicide d	etermined		RE	ESIDE	NCE			23	333 E	•	FAYE	ETTE	STREET
COMPLET	29a. CERTIFIER (Check only one) 1 CERTI	FYING PHYSIC	CIAN: To the best of m	y knowledge, de	eath occurred	at the lime,	data and	place, and	due to the	cause(a) an	d man	ner as stat	ed.	) and manner as stated.
	296 SIGNATURE AND TITLE		0	1							_,			
BE	/shi	1-46	alle	5-41				O.C.						(Month, Day, Year)
2	50. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUSE	OF OEATH (ITE	M 27) (Type, F	Print)				-				
	MARIO F. C	36CL	TILLIA	T.J.I F	Penn	Stre	et.	Bal	TIMO	ore.	Ma	ryla	and	21201
86	31. DATE FILED (Month, Pay, Y	had	32 REGISTRAR	200000000000000000000000000000000000000										2120.1



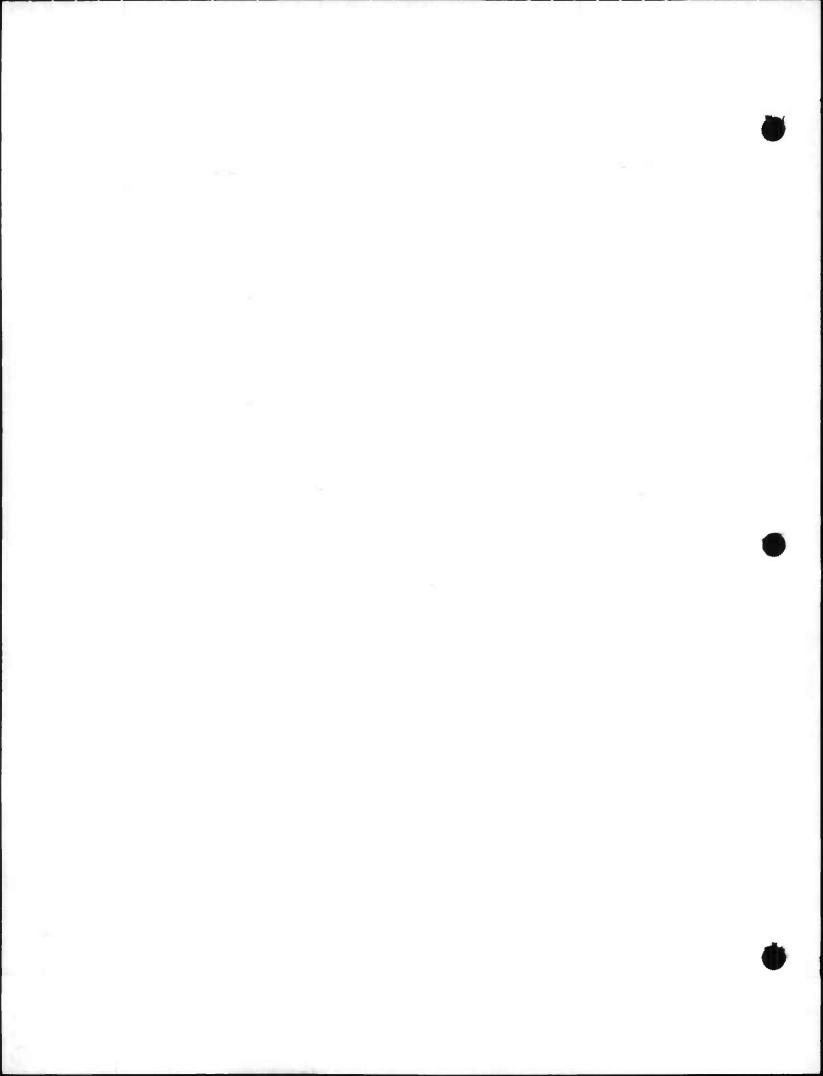
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First	Micicle Last)					7112				neu.			_	
	LUCY	,	MARY			Ľ	IICKS				2. DATE OF DEATI MONTH 04	DAY	0	YEAR3	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In vrs. last birthday)			IF UNDER 1 YEAR   IF UNDER 24 HRS.								3.:40 AM M	
. 1	220-16-7355	1 M 2 VF	85	,		ONTHS DA	$\rightarrow$	HOURS	MIN.	7. DATE OF BIRTH (Month, Day, Yea	)	_	6. BIRTHP Country)	LACE (State or Foreign	
						10000	111	(Month, Day, Year) 09-22-1907			MARYLAND				
or	90. FACILITY NAME (# not institution, give street and number)  NORTH ARUNDEL HOSPITAL ASSOCIA						b. CITY, TOV				ATH		9c. COUP	NTY OF DEA	
DIRECTOR	NORTH ARE	JNDEL I	HOSPITAL	ASSO	CIATI	ON	GI	LEN	I BU	RNIE				A.A	. COUNTY
띮	10e. STATE	10b. COUNTY	,		10	0c. CITY T	TOWN OR LO	CATIC	ON					1	10d. INSIDE CITY
E	MARYLAND	ANN	NE ARUNDI	EL	"		LEN E								LIMITS?
	10e. STREET AND NUMBER	<u> </u>										_			1 ☐ YES 2 💢 NO
FUNERAL	179 VIRGINI	A TANE	7.				ľ	101.	2IP COD	061				ZEN OF WH	IAT COUNTRY?
Z	11. MARITAL STATUS		12. WAS DECEDEN		V2		<del>,                                    </del>					1			
	1 Never Married 2	Married	FORCES? 1	YES	2 XNO	)	It yes	s, apec	cify Cuba	OF HISPAN In, Mexicer	IC ORIGIN? (Specify n, Puerto Rican, etc.)	Yes o	r No	14. RACE - Black,	- American Indian, White, etc.
BY	3 📉 Widowed 4 🗌 Divo		IF YES, GIVE Y	WAR OR DATE	ES		1 🗆	YES 2	XXNO	Specify.				Specify:	WHITE
	15. DEC	EDENT'S EDUC	CATION	1.	16e. DECED	ENT'S LIS	UAL OCCUE	MATION	ч		16b. KIND OF	DITO	I I	LIGHTON	
E	(Specify only Elementary/Secondary (0	highest grade	completed) College (1-4 or 5		(Give ki		k done during			ng	TOU. KIND OF	BOSIF	4E99/IND	OSINT	
7	6		NONE	*)	НО	MEMA	KER				OWN	НО	ME.		
COMPLETED	17. FATHER'S NAME (First, M							$\neg$	16 MOTI	HER'S NAM	ME (First, Middle, Mei				
	JOHN	E	ECKMAN							ORA	me (First, Micole, Mer		AIR		
H	19a. INFORMANT'S NAME (7	vpe/Print)			195 M	AILING AD	nnesse /Sta	201 220	of Museubas	or Orient O	ioute Number, City or	Y	0	0-40	
2	ROBERT	S.	HICKS								, CROWNS				21032
	20e. METHOD OF DISPOSIT	ION		000 0	1 405 445	0.15000	DISPOSITION								
	1 Genetic 2 Cremetic 4 Donation 5 Diper	n 3   Remo	oval from State	Cemete	ery cremato	ary or other	place) CHURCH			מחחע	1/1/10			City or Town	
	21. SIGNATURE OF FURERA		ENSEE /	/ JEE	PIPHA	MY C	_	_		SS OF FAC	1003	DE	NTON	, MA	RYLAND
	Som	nt/	1511	dete	M		1	L AND	ADDITE	33 OF FAC		ET	ON F	UNER	AL HOME
_	71010	w,		ugu			l SE	ECO	ND A	AVE.,	, S.W., C	SLE	N BU	JRNIE	, MD.21061
	23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest,														
1	IMMEDIATE CAUSE (Fin			00 Dii 000	IIII.	1									Interval Between Onset and Death
I	disease or condition	<b>→</b> ,	ı.		/-	Jep.	Sin								
			DUE TO	(OR AS A C	ONSEQUEN	NCE OF):									
2	Sequentially list conditi	000	D												
CERTIFICATION	If any, leading to immediate. Enter UNDERLYI	diata	DUE TO	(OR AS A C	ONSEQUEN	NCE OF):									
5	CAUSE (Disease or Inju		DUE TO	(00.45.4.0	0110501151										
Ë	that initiated events resulting in death) LAS	т .	DOE TO	(OR AS A C	ONSEQUEN	NCE OF):									
当!			1												
	PART II. Other algnifica				not resul	iting in t	he undart	ying	cause g	given in f					VERE AUTOPSY FINDINGS
EDICAL	Deep	venous	thomb	own								FORMI			MAILABLE PRIOR TO COMPLETION OF CAUSE
	Ischem	ic b	owel p	-anible	,	Law	1 int	200	chim	4	1 YES	2 _	NO		F DEATH?
≥	Arterio		sufficience		7 6	2	1 -1				-			,	☐ YES 2 ☐ NO
₹	25. WAS CASE REFERRED TO		Ja Carre	7					CE OF D	_/_	ck only one)	_			
S	EXAMINER?		HOSPITAL:	EB/Outnet	lant 2 D D		THER:								
PHYSICIAN:	27. MANNER OF DEATH		26s. DATE OF			b. TIME O		INJUF		sidence (	Other (Specify)  26d. DESCRIBE HO	W IN I	LIBY OCC	TIRED	
		Pending	(Month, D	ay, Year)		INJURY	Υ	WORK	K7	ON F	ZOU. DESCRIBE NO	** 1113	ONI OCC	ONED	
B	3 Suiside	nvestigation	26e. PLACE O	F INJURY -	- At home, f	form, stree				-	261. LOCATION (Stre	et end	1 Number	or Rumi Pou	da Mumbar
COMPLETED		Could not be letermined	building,	stc. (Specify)	)					ľ	City or Town, St		redinadi	or moral mod	in trumon,
<u>"</u>	29e. CERTIFIER	EVINO BUYOU			Ų.	_	524	_				_			
₹											to the cause(e) end				
8			. On the best of a					n, des	ntn occur	ed at the t	lime, date end place.	end o	due to the	couse(s) e	and menner ee stated.
8	296. SIGNATURE WAS TITLE	CENTIFIER	118	1	PHYG	HICH	19	1		NSE NUM		2	9d. DATE	SIGNED	fonth, Day, Year)
2	10000	men.	AVV						D.	403	121		P 4	1/8/	73
	30. NAME AND ADDRESS OF	,							7D / C	T 1737	DUDUEE	10	0.	1061	
	MAHESH S					TCHIL	HWY	, 5	sE/G	LEN .	BURNIE,	MD.	2.	1061	
	APR 091	993	Julia Davi	R'S SIGNATI	une Indett										



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	1. DECEDENT'S NAME (First, Middle, Le.	JANTZEN		OF DEATH	2. DATE OF DEATH MONTH 4-7-9.		3. TIME OF DEATH 8:35 P M
	4. SOCIAL SECURITY NUMBER 179-09-2484		yrs, lest birthday) IF UNDER 1 YI YRS. MONTHS DI	AR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIR Cou	THPLACE (State or Foreign ntry)
	9a. FACILITY NAME (If not institution, given	e street and number)	9b. CITY, TO	WN OR LOCATION OF DE	9-6-1916 EATH	9c. COUNTY OF	NNSULVANÍA DEATH
TOR	Franklin Squar	e Hospital	R	ossville		Baltim	ore
DIRECTOR	Maryland 10b. cou	Baltimore	10c. CITY, TOWN OR L	OCATION DU	ndalk		10d, INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 8118 Bullneck				1222	Unit	ed States
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 NO If yo	DECENDENT OF HISPAN s, specify Cuben, Mexica YES 2 NO Specify	n, Puerlo Rican, etc.)	Bla	CE — American Indian, ick, White, atc.
ETED	15. DECEDENT'S E (Specify only highest gn Elementary/Secondary (0-12)	DUCATION Inde completed)  College (1-4 or 5+)	16e. DECEDENT'S USUAL OCCU (Give kind of work done durin life. Do NOT use retired.)	PATION g most of working	16b. KIND OF BU	SINESS/INDUSTRY	
COMPLET	12th Grade	Conlege (1-4 or 5+)	Truck Dri	ver	Index	pendent	
COM	17. FATHER'S NAME (First, Middle, Last)			IS. MOTHER'S NA	ME (First, Middle, Maiden		
BE (	William T. Jan 199. INFORMANT'S NAME (Type/Print)	tzen			E. Kocher		
TO B	Roberta Boland		196. MAILING ADDRESS (SI		noune Number, City or Tow Nack. Mar		21 000
	20a. METHOD OF DISPOSITION  1 [X] Burlel 2 Cremation 3 Re	20b. P	PLACE AND DATE OF DISPOSITIO	N (Name of	DATE 20c 10	CATION — City or	
	4 Donation 5 Other (Specify)	Go	tery, cremetory or other place) WIDENS OF FAI	th Cem. 4/	10/93 0	verlea.	Maryland
	21. SIGNATURE OF FUNERAL SERVICE	DOENIGE	22. NAN DU 79	ne and address of fa da-Ruck Fu 22 Wise Au	aurv neral Home enue Duna	e of Duna	
	23. PART I. Enter the diseases, o shock, or heart fallur	or complications that caused to be. List only one cause on eac	tha daath. Do not enter the	mode of dying, suci	h as cardiac or reap	iratory arrest,	Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	. Adult respin		ss syndrom	e		Onset and Death
	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	- Pancreatitis	S. CONSEQUENCE OF):				
CERTIFICATION	CAUSE (Disease or Injury that Initiated events resulting in death) LAST	DUE TO (OR AS A C	CONSEQUENCE OF):				
4	PART II. Other aignificant conditi	iona contributing to death but	t not resulting in the under	lying cause given in			Ib. WERE AUTOPSY FINDINGS
·   3	7				PERFOR		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDIC							
	25. WAS CASE REFERRED TO MEDICAL			6. PLACE OF DEATH (Ch	eck only one)		
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO	HOSPITAL:	OTHER:	6. PLACE OF DEATH (Che			
PHYSICIAN:	EXAMINER?	1 Inpetient 2 ER/Outpet  26a. DATE OF INJURY (Month, Day, Year)	lent 3 DOA OTHER: 4 Nursing 28b. TIME OF 18JURY M 1	Home 5 Residence INJURY AT WORK? YES 2 NO		NJURY OCCURED	
ED BY PHYSICIAN:	EXAMINER?  1 VES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending	26a. DATE OF INJURY (Month, Day, Year)	OTHER:  3 DOA 4 Nursing  28b. TIME OF INJURY M 1  - At home, farm, street, factory,	Home 5 Residence INJURY AT WORK? YES 2 NO	6 Other (Specify)	and Number or Rura	I Route Number,
LETED BY PHYSICIAN:	EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation 3 Suicide 6 Could not to determined  29a. CERTIFIER Check pay	26e. DATE OF INJURY (Month, Day, Year)  28e. PLACE OF INJURY 28e. PLACE OF INJURY	OTHER:    OTHER:	Home 5 Residence INJURY AT WORK? YES 2 NO office	6 Other (Specify)  28d. DESCRIBE HOW I  28f. LOCATION (Street City or Town, State)	and Number or Rura	
BE COMPLETED BY PHYSICIAN:	EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation 3 Suicide 6 Could not to determined  29a. CERTIFIER Check pay	28e. DATE OF INJURY (Morth, Day, Year)  28e. PLACE OF INJURY building, etc. (Specify  YSICIAN: To the best of my knowled INER: On the basis of examination a	OTHER:    OTHER:	Home 5 Residence INJURY AT WORK? YES 2 NO office  date end place, and due on, death occured at the	6 Other (Specify)  28d. DESCRIBE HOW I  28f. LOCATION (Street City or Town, State)  to the cause(e) and mai	and Number or Rura nner as stated. ad due to the cause 29d. DATE SIGNE	e(a) and menner ea stated.
E COMPLETED BY PHYSICIAN:	EXAMINER?  1 VES 2 NO  27. MANNER OF DEATH  1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not to determined  29e. CERTIFIER Check only One) 2 MEDICAL EXAMINER  **REDICAL EXAMINER**  **REDIC	28e. DATE OF INJURY (Morth, Day, Year)  28e. PLACE OF INJURY building, etc. (Specify  YSICIAN: To the best of my knowled  NER: On the basis of examination a	DOA OTHER: 4   Nursing 28b. TIME OF HJURY M 1  - At home, farm, street, factory, dge, death occurred at the Hme, and/or investigation, in my opinion	Home 5 Residence INJURY AT WORK? YES 2 NO office  date end place, and due pon, death occured at the	6 Other (Specify) 28d. DESCRIBE HOW I 28f. LOCATION (Street. City or Rown, State) to the cause(e) and mailtime, date and place, an	and Number or Rura	e(a) and menner ea stated.
BE COMPLETED BY PHYSICIAN:	EXAMINER?  1 VES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation  2 Accident Investigation  3 Suicide 6 Could not be determined  29c. CERTIFIER Chock pay 2 MEDICAL EXAMINER  290. SEDMATURE AND TITLE OF CERTIF	28e. DATE OF INJURY (Morth, Day, Year)  28e. PLACE OF INJURY building, etc. (Specify  YSICIAN: To the best of my knowled  NER: On the basis of examination a	OTHER: 4   Nursing 28b. TIME OF INJURY M 1  -At home, farm, street, factory, )  dge, death occurred at the Hme, and/or investigation, in my opini  H (ITEM 27) (Type, Print)  IN Square Dr	Home 5 Residence INJURY AT WORK? YES 2 NO office  date end place, and due pon, death occured at the	6 Other (Specify) 28d. DESCRIBE HOW I 28f. LOCATION (Street. City or Rown, State) to the cause(e) and mailtime, date and place, an	and Number or Rura	e(a) and menner ea stated.



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

			TIEGISTIAN			-NITTO	AIE OF	DEAIL		REG. NO.			
	Y	- 3	1. DECEDENT'S NAME (First, Middle, Last	)					2. DAT	E OF DEATH		YEAR 3.	TIME OF DEATH
			BASIL JOHNSON						14		5 0	13	450 PM
			4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH	-	BIRTHPL	ACE (State or Foreign
	20		218-24-3538	1 M 2 □ F	62	YRS.	THS DAYS	HOURS MIN.	APR	th, Day, Year) [L 7, 19	30 P	RINCI	E GEORGE C
	3 should	_	9a. FACILITY NAME (If not institution, give			9b	CITY, TOWN	OR LOCATION OF	DEATH		9c. COUNT	Y OF DEAT	N
	2,3	5	ST. AGNES HOSPITA	AL			BALTI	IMORE					
	- S	딦	RESIDENCE OF DECEDENT  10a, STATE  10b, COUN	TY		100 CITY TO	WN OR LOCA	TION					
	Pag	DIRECTOR	MARYLAND BA	ALTIMORE			TONSVI						d. INSIDE CITY LIMITS?
	Ë		10e. STREET AND NUMBER	LETTIONE		UA		f. ZIP CODE			40 - 017171		T COUNTRY?
	Sit De	5	55 WADE AVENUE				, ,	212	28				
	physician. burial-transit permit. Pages 1, 2,	FUNERAL	11. MARITAL STATUS	12. WAS DECEOEN	T EVER IN U.S. ARI	MED	13 WAS DE	CENDENT OF NISP		N2 (Caselfy Ves		.S.A.	American Indian,
020	physi		1 Never Married 2 Married	FORCES? 1 IF YES, GIVE W	YES 2 X N	0	If yes, sp	secify Cuben, Maxi	can, Puarto	Rican, etc.)	U NO_	Black, W	fhita, atc.
5-0020	as the l	ВУ	3 Widowed 4 Divorced				1 12	2 LT NO Spec	жу.			Specify:	WHITE
21	atter	ETED	15. DECEDENT'S ED (Specify only highest grad	UCATION le completed)	16a. DE(	CEDENT'S USL	AL OCCUPATE	ON set of working	16	b. KIND OF BUS	INESS/INDU	STRY	
21	for t	9	Elementary/Secondary (0-12)	College (1-4 or 5+	Hida .	Do NOT use rei	red.)	out or working			773.777	MALDI	
2	hospi ached	COMPL	10TH GRADE			UIV	KNOWN				UNK	NOWN	
LA	by the hospital or attending physician.  be detached for use as the burial-tran  at once.	8	17. FATHER'S NAME (First, Middle, Last) UNKNOWN					18. MOTNER'S N			Sumame)		
RY	ed by	핆								CNOWN			
MARYLAND	s retained by the hospital or att 5 should be detached for use notified at once.	임	19a. INFORMANT'S NAME (Type/Print) CINDY HANNA		19b	ALTER	P. CAR	RTER CTR CATONS	-PRES	TON BI	DG - II	ode) NTT 8	2
E,			200_METHOD OF DISPOSITION		P	.O. BO	X 3235	-CATONS					
BALTIMOR	after death. Page 6 may be by the funeral director, page imoval.	- 1	1 ABurial 2 Cremation 3 Rer	noval from State	cemetery, crer	ND DATE OF D	vace)		OA		CATION — CI	ty or Town,	Stata
×	direc direc		4 Donation 5 Other (Specify)	ICENSEE	IETERY ND ADDRESS OF F	2/9 WOODLAWN							
L	death. Pag e funeral dir al. examiner		( ) a un	77	n			ARD FUNE		IOME, I	NC.		
BA	the fu		* Cum	KIND	ner		4107	WILKENS	AVEN	UE-BAL	TIMOR	E, MI	21229
	in the		23. PART I. Enter the diseases, or ehock, or heart fellure	complications that Liet only one caus	ceused the dec	eth. Do not e	nter the mo	ode of dying, au	ch aa ce	diac or reepi	retory arrea	ıt,	Approximata interval Between
			IMMEDIATE CAUSE (Finel disease or condition	1.461									Onset and Death
, ,	within 24 npletely fills cremation, vent, the		disease or condition LUNG CANCER  a. DUE TO (OR AS A CONSEQUENCE OF):										7 years
68760,	8 9 9			DUE TO	OR AS A CONSEC	UENCE OF):							
68	at par	ON	Sequentially list conditions,	b	OR AS A CONSEC	HENCE OF			_				ļ 
ВОХ	or to	RTIFICATION	If any, leading to immediate cause. Enter UNDERLYING										
	certificate ding physi lygiene pri other to	윤	CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF):										
P.0	으로 늘	E	resulting in death) LAST	4									
		S	24 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	d									
CORDS	1 2 d a	DICAL	PART II. Other eignificent condition  DEHYDRA		deeth but not re	eaulting in th	e underiyin	g ceuee given i	n Part I.	24a. WAS AN . PERFOR			RE AUTOPSY FINDINGS
0	uires that signed by Health and	EDK	- VOIT/VRA	TWN						1 TYES 2	NO	CO	MPLETION OF CAUSE DEATH?
	been sign to of Heat	Σ										1[	YES 2 NO
L	23 Pep	Z											
OF VITAL RE	YSICIAN: The law s certificate has I th the State Dept od, or item 23	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OT	26. PI	LACE OF OEATN (C	heck only o	ne)			
>	SICIAN: The certificate the State the State I, or Hen	> 1	1 Nes 2 No	Inpatient 2 🗆		DOA 4	Nursing Horr	ne 5 🗆 Residence	_				
	The Charles	E	1 Netural 5 Pending	28a. DATE OF I (Month, Da		28b. TIME OF INJURY	WC	IURY AT DRK?	28d. DE	SCRIBE HOW IN	IJURY OCCU	RED	
NO	1	) <u>6</u>	2 Accident Investigation	28a PLACE OF	INJURY — At hon			YES 2 NO	-				
DIVISION	S S S		3 Suicide 8 Could not be detarmined	building, a	itc. (Specify)	ne, larm, stree	, явстогу, отпе	•	28t. LOC	or Town, State)	nd Number or	Rural Route	Number,
≥	DR AT DIRECT Hours		29a. CERTIFIER										
	マーンド が	COMPLE	(Check only	SICIAN: To the best of i									
	TO THE HOSPITAL TO THE FUNERAL DE filed within 72 I	8	2 MEDICAL EXAMIN	_ 0 0 0	amination and/or in	weatigation, in	my opinion, d	leath occured at th	e time, det	and place, and	dua to the	:ause(s) and	d manner ea stated,
	H H H P	H	29b. SIGNATURE AND TITLE OF CERTIFIE	100-00-	N M. Bu	acu		29c. LICENSE NU	JMBER		29d. DATE S		onth, Day, Year)
	TO THE HOSPIT TO THE FUNERA DE filed within 7 IMPORTANT: I	p P	RODELW M. BUCK		_/_/	DENT					<b>&gt;</b> 4	47/9	3
			30. NAME AND ADDRESS OF PERSON WIR		E OF OEATN (ITEM T · AGNE			300 0	MThal	Auto	D4: -		
			31. DATE FILEO (Month, Day, Year)			حس د	IIML	300 0	HIUN	AVE.	BALTIT	MORE	MD 21229
			APR 09 1993	32, REGISTRAF	idson-Rang	2.00							
	L		MEN 0 9 1333	Hama was	10000 - Nove	المالك							

BALTIMORE, MARYLAND 21215-0020	leath. Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	xaminer must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	O THE I OS THE MOST ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	O THE PARENCE OF CODE: After this certificate has been signed by the attending physician and completely filled in by the fun- e filed within emount after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR		STATE OF I	WARYLAND	) / DEPAI CERTIF	RTMEN	T OF H	EALTH	AND	MENT			3	09970	
	1. DECEDENT'S NAME (First	Middle Leet			CENTIF	ICATI	COP	DEA	IH		REG. NO				
	WILLIA	M	Ε.	J	ORDA	N				2. DAT MON 4	TE OF DEATH	199	YEAR 3	3. TIME OF DEATH 10:09A	м
	4. SOCIAL SECURITY NUMBER 218-05-36		5. SEX	6. AGE (In yrs. 7 ()		IF UNDER	R 1 YEAR	IF UNDER	24 HRS.	7. DAT	E OF BIRTH ofth, Day, Year) 0-19-2		6. BIRTHE		in
	9e. FACILITY NAME (If not in				1110.	Tari am					1-19-2			yland	
OR	4		EDERAL	STREE	СТ	96. CITY, TOWN OR LOCATION OF DEATH  BALTIMORE CITY  none						ATH			
5	RESIDENCE OF DEC												.0110		
DIRECTOR	10a. STATE MARYLAND	106. COUNTY	ONE	BALTIMORE CITY								10d. INSIDE CITY LIMITS? 1 YES 2 NO			
FUNERAL	100. STREET AND NUMBER	E BERA	AL STRE	ET		_	101	ZIP CODI	121	3			ZEN OF WI	STATES	
ž	1623 E. FEIDERAL STREET					12	WAS DEC				10 10 10 14 W				
BY FL	1 Never Married 2 1 3 Widowed 4 Divo		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 2	NO		If yes, sp	ecify Cuba	ın, Mexica	in, Puerte	ilN? (Specify Yes o Rican, atc.)	or No-	14. RACE Black, Specify	- American Indian, White, etc.	
	W.W.II AFRICA							RICA	N AMERI	CAI					
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working														
<b>"</b>	Elementary/Secondary (0-12) College (1-4 or 5+) life. Do NOT use retired.)														
MP	8th grade none laborer Department of S									Sanita	tic				
8	17. FATHER'S NAME (First, Middle, Last)							18. MOTI	HER'S NA		, Middle, Meiden				
BE	FRANK JORDAN							W.	ILL	IE A	Ann He	eadle	2 V		
힏	FRANK JORDAN  WILLIE Ann Headley  19e. INFORMANT'S NAME (Type/Print)  19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)														
F	JAMES A. JORDAN 1613 E. Lanvale Street Baltimore, Md. 2121:														
	20a. METHOD OF DISPOSITION  1 Camellon 3 Removal from State  20b. PLACE AND DATE OF DISPOSITION (Name of A Camellon City or Town, State Cemetery, crematory or other place)														
	4 Donation 5 Other	(Specify)	oval from State	GAF	RISO	N + C	DRES	T V	A.CI	EM.	OWI	NGS	MIT	LS. MD.	
	21. SIGNATURE OF FUNERAL	L SERVICE LIC	ENSEE		(	22	'AL'	IN	B .	CILITY SCRI	UGGS F	UNE	RAL	HOME	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest,   Appr									MD.						
CERTIFICATION	iMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  Last only one cause on each line.  (ARTERIOSCLEROTIC CORONARY ARTERY DISEASE)  Oue TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):														
MEDICAL (	PART II. Other aignifica	nt condition	e contributing to	deeth but no	t resulting	in the un					24a. WAS AN PERFOR YES 2		6	VERE AUTOPSY FINDING MAILABLE PRIOR TO COMPLETION OF CAUSOF DEATH?	
										_					
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	11000					ACE OF DI	EATH (Ch	eck only (	one)				
i	1 XYES 2 NO		HOSPITAL:	ER/Outpatient	3. DOA	OTHER 4 - Nun		5 (X Re	sidence	6 🗆 Oth	ner (Specify)				
Ę	27. MANNER OF DEATH		28e. OATE OF	INJURY	28b. TIM	E OF	28c. INJU	JRY AT			ESCRIBE HOW II	NJURY OCC	URED		
10		Pending Investigation	(Month, D	=y, redf)	INJ	URY M	1   Y	RK? ES 2	NO [						
	2 Accident 3 Suicide 8 Could not be 4 Homicide datermined					street, fact						ute Number,			
COMPLETED			CIAN: To the best of												
5	one) 2 MEDI	CAL EXAMINER	P: On the beele of e	cardination end/	ofinventigatio	n, in my o	pinion, de	ath occur	ed at the	time, dat	te end place, en	d due to the	e ceuse(e)	end manner ee stated	ı.
	296 SIGNATURE AND TITLE	OF CENTIF AT	RVI.	1				29c. LICE					SIGNED (	Month, Day, Year)	
2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETEO CAU	7 III 1 ~					OCM			▶4	/	1993	
	31. DATE FILED (Month, Day,		32. REGISTRA	R'S SIGNATURE		n S	tree	et,	Bal	tim	ore, l	Mary	land	21201	
	APR 09		I lia Da	idson R	ndelle										

notified

9 must examiner medical the event. traumatic other 6 any Injury, has been of P r this certificate hit with the State D 6 Is marked, FUNERAL DIRECTOR: After t within 72 hours after death

28

Item

IMPORTANT: II

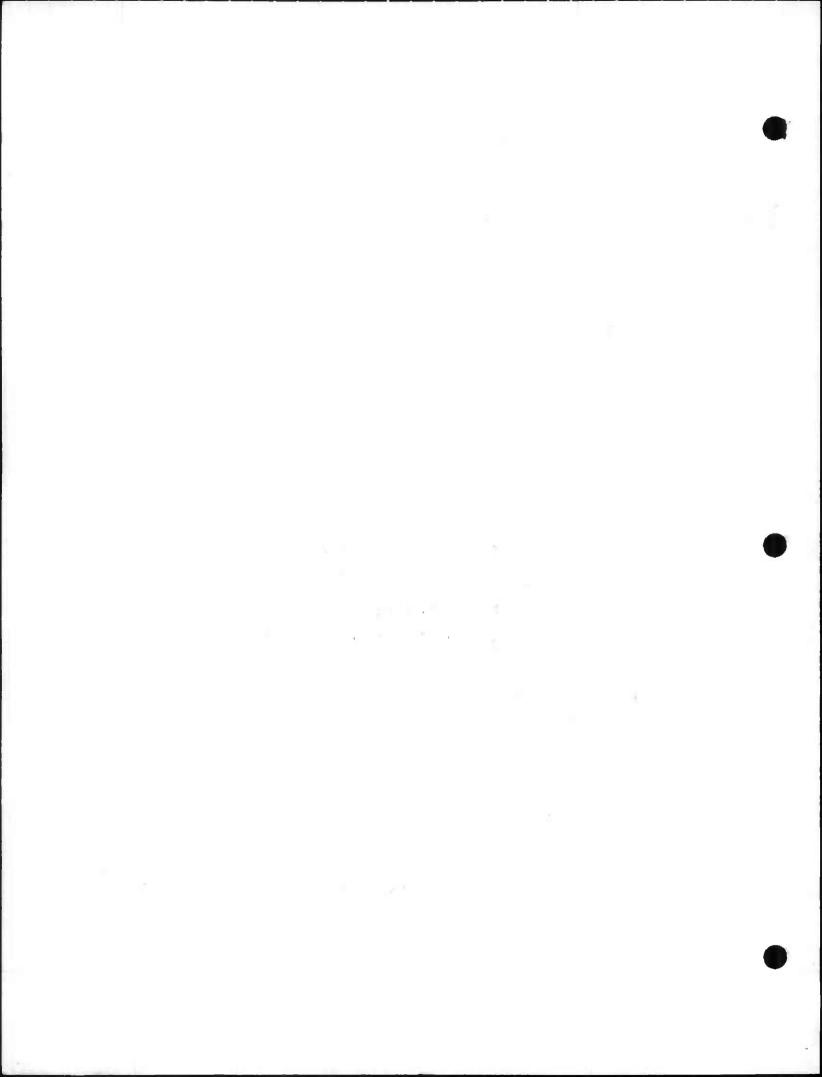
**'9**' 1993

THE Delt 223

REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH DAY 3. TIME OF DEATH WILLIE ANDREW **JOHNSON** 3r. APRIL 4,1993 4:48pm 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 2/22/44 IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign HOURS 1 🗆 📈 2 🗆 F YRS. 579-54-3157 49 Georgia 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH Sc. COUNTY OF DEATH DIRECTOR COMMUNITY DOCTORS HOSPITAL LANHAM-SEABROOK PRINCE GEORGE'S CO RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md PG Suitland 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2302 Brooks Drive 20746 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 Y YES 2 NO IF YES, GIVE WAN OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Married 1 YES 2 NO Specify: BY 3 Widowed 4 Divorced Black (Army 1946-48)COMPLETED 15. DECEDENT'S EDUCATION pecify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY follege (1-4 or 5+) 12 yrs Administration 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)

Idies P Fouch Willie A Johnson BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Karen Johnson Same as 10a,b,c,d,e,&f 20a. METHOD OF DISPOSITION
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE 1 Donation 5 Other (Specify) Md Veterans Cemetery 4/12/93 Chelenham. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 6 John T Rhines Co., Inc. 3030 12th St NE, DC 20017 23. PART L'Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such a Approximate shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition resulting in death) MEDICAL CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. ON ner aignificant conditions contributing to death but not resulting in the under 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE 1 | YES 2 | 10 OF DEATH? 1 \_ YES 2 \_ NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 | YES 2 (L) 1 Inpatient 2 ER/Outpatient 3 DOA ne 5 🗌 Reside 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO B 2 Accident 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 6 Could not be 4 Nomicide 1 CERTIFYING PHYSICIAN: dge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. 2 MEDICAL EXAM BE 2 DENNIS LEWIS SUITE U-1 GREENBELT RD COLLEGE TARK 6201 17 REGISTRAR'S SIGNATURE

فالماراهاء



FOR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCICAG

	1 - STATE REGISTRAR		CI	ERTIF	ICATE C	F DEAT	ГН	REG. NO.			
(6)	1. DECEDENT'S NAME (First, Middle, Last	)						2. DATE OF DEATH			. TIME OF DEATH
i	CHARLES	Н.	LAND	ECK				MONTH DA		YEAR 3	M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	it birthday)	IF UNDER 1 YE	IF UNDER	24 HRS.	7. DATE OF BIRTH			ACE (State or Foreign
	352-10-6425	1 🔀 M 2 🗌 F	90	YRS.	MONTHS DAT	B HOURS	MIN.	(Month, Day, Year)		Country)	
	9a. FACILITY NAME (If not institution, give	street and number)			9h CITY TOV	N OR LOCATI	ON OF DE	12-15-02	- COUN	IIII	
œ	8615 Richmond A					ville	ON OF DE	Sin	A		
읽	RESIDENCE OF DECEDENT	ve.			Paik	ville			Ba.	timo	re
DIRECTOR	10e. STATE 10b. COUN	TY		10c. CIT	Y, TOWN OR LO	CATION				1	Od. INSIDE CITY
1	Maryland Balt	imore		Par	rkville	:				_   ,	LIMITS?
A	10s. STREET AND NUMBER					10f. ZIP COD	E		10g. CITIZ		AT COUNTRY?
FUNERAL	8615 Richmond A	lve.				21234	4		U.S	. A .	
3	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AR	IMED	13. WAS			C ORIGIN? (Specify Yes			- American Indian,
BY F	1 Never Married 2 🔀 Married 3 Widowed 4 Divorced	FORCES? 1	YES 2 🔀	40	If yes		n, Maxican	, Puerto Rican, etc.)		Black, Specify:	White, etc.
- 1	15. DECEDENT'S ED	UCATION	16a. DF	CEDENT'S	USUAL OCCUP	ATION		16b. KIND OF BUS		White	3
	(Specify only highest gra-	de completed)	(G	ive kind of a	work done during	most of working	ng	ING. KIND OF BUS	MINESS/INDI	JSTHT.	
2	unknown	College (1-4 or 5		perat	or			Heavy 1	Fauin	men+	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			POLA		to MOT	UED'S NAS	IE (First, Middle, Maiden		Ment	
	Henry Peter	<u> </u>	Tan	deck		To. MOTO			Sumeme)		
BE	19a. INFORMANT'S NAME (Type/Print)				ADDRESS (OL	Mary  DDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code)					
임	Michael D. Lande	ck						Head, Md.		,	
					OF DISPOSITION		aran		CATION — C		
	20g, METHOD OF DISPOSITION  1  Suriel 2  Cremation 3 Re 4  Donation 5  Other (Specify)	cemetary, cre	matory or o	ther place)							
	21. SIGNATURE OF FUNERAL SERVICE I	Falkw	<u>ioou</u>	Cemete:	E ANO ADDRE	SS OF EAC	4-10 Par	KVIII	е, м	a.	
- 1						uneral Hom	e, Ir	ic.			
					105	York	Rd.	Towson, M	d. 2]	204	
	23. PART I. Enter the diseases, or shock, or heart fellure	compileations that	t coused the de	ath. Do r	not enter the	mode of dy	ing, such	as cardiac or respi	ratory arm	est,	Approximate
- 1	IMMEDIATE CAUSE (Final		779.11.2.3.2.11.11.11		100.	A	. 1	- 4 4 .			interval Between Onset and Death
- 1	disease or condition resulting in death)	PACO	TE M	foc	ועיוה	AC 1	MI	Arcto	N		
- 1			(OR AS A CONSEC		F):						
z I	Sequentially list conditions,		EMI								
Ĕ	If any, leading to immediate	DUE TO	(OR AS A CONSEC	QUENCE O	P: 15	CAD	LA	4US .			
2	cause. Enter UNDERLYING CAUSE (Disease or Injury	c C 197	1001140	1144	TIE	904	ON	40)			
CERTIFICATION	that initiated events resulting in death) LAST	A O T	(OR AS A CONSEC	DUENCE OF	P. 20-	tic	110	ART DI	SF	55	-
H H		d. PPI	<u> </u>	0.0		100	7-	1.01		76	
	PART ii. Other significant condition	one contributing to	death but not r	esuiting	in the underl	ying cause o	given in F	Part I. 24s. WAS AN	AUTOPSY	24b. W	PERE AUTOPSY FINDINGS
CAL								PERFOR		A	MAILABLE PRIOR TO OMPLETION OF CAUSE
MED							_	1 YES 2	∐ NO		F DEATH?
								_		'	YES 2 NO
₹	25. WAS CASE REFERRED TO MEDICAL	I			26	. PLACE OF D	FATH (Che	ck only one)			
	EXAMINER?	HOSPITAL:	EB/Outpetlant 3	_ noa	OTHER:						
		inpution, E		28b. TIM		INJURY AT	sidence (	28d. DESCRIBE HOW II	HIBY OCC	IDED	
HYSIC	27. MANNER OF DEATH	28a. DATE OF			URY	WORK?					
PHYSICIAN:	27. MANNER OF DEATH  1 Netural 5 Pending	(Month, D		1743		YES 2	NO				
B	27. MANNSR OF DEATH  1 Netural 5 Pending 2 Accident Investigation	(Month, D	ey, Year)	<u></u>	M 1	YES 2	NO	281. LOCATION /Street a	and Mumber	v Burel Bru	da Number
B	27. MANNSH OF DEATH  1 Netural 5 Pending	(Month, D		<u></u>	M 1		NO	281. LOCATION (Street a City or Town, State)	nd Number	or Rural Rou	ite Number,
B	27. MANNER OF DEATH  1 V Netural 5 Pending Investigation 3 Suicide 8 Could not be determined	26a. PLACE O building,	F INJURY — At ho	me, farm,	M 1	ffica		City or Town, State)			ite Number,
B	27. MANNER OF DEATH  1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be detarmined  29a. CERTIFIER (Check only) 1 CERTIFYING PHY	(Month, D 26a. PLACE O building,	F INJURY — A1 ho etc. (Specify)  my knowledge, de	me, farm,	M 1	office	, and due t	City or Town, State) to the cause(a) and man	ner as state	d.	
	27. MANNSFI OF DEATH  1  Netural	28s. PLACE 0 building,  SICIAN: To the best of elements of element	F INJURY — A1 ho etc. (Specify)  my knowledge, de	me, farm,	M 1	office	, and due t	City or Town, State)	ner as state	d.	
COMPLETED BY	27. MANNER OF DEATH  1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be detarmined  29a. CERTIFIER (Check only) 1 CERTIFYING PHY	28s. PLACE 0 building,  SICIAN: To the best of elements of element	F INJURY — A1 ho etc. (Specify)  my knowledge, de	me, farm,	M 1	office fate and place n, death occur	, and due t	City or Town, State)	ner as state	d.	ind manner as stated,
BE COMPLETED BY	27. MANNER OF DEATH  1  Netural 5  Pending Investigation 2  Accident Investigation 3  Suicide 8  Could not be detarmined  29a. CERTIFIER (Check only one) 2  MEDICAL EXAMINATION OF CERTIFIER AND TITLE OF CERTIFIER	28a. PLACE O building, SICIAN: To the best of e	ey, Year)  F INJURY — A1 ho etc. (Specify)  my knowledge, de termination and/or i	ath occurr	M 1	office fate and place n, death occur	, and due t	City or Town, State)	ner as state	d, cause(a) a	ind manner as stated.
COMPLETED BY	27. MANNER OF DEATH  1 Netural 5 Pending Investigation 2 Accident 8 Could not be determined  29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINATION OF CERTIFIER 30. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON W.	SICIAN: To the best of each of the best of	F INJURY — A1 ho etc. (Specify)  my knowledge, de xamination and/or i	ath occurring the state of the	M 1 street, factory, conditions on, in my opinio	diste and place n, death occur 29c. LICE	, and due to det the t	City or Town, State)	ner as state	d, cause(a) a	ind manner as stated,
BE COMPLETED BY	27. MANNER OF DEATH  1  Netural 5  Pending Investigation 2  Accident Investigation 3  Suicide 8  Could not be detarmined  29a. CERTIFIER (Check only one) 2  MEDICAL EXAMINATION OF CERTIFIER AND TITLE OF CERTIFIER	SICIAN: To the best of BER: On the basis of ending.  HO COMPLETEO CAUSTIAN 2314	F INJURY — A1 ho etc. (Specify)  my knowledge, de xamination and/or i	ath occurring the state of the	M 1 street, factory, conditions on, in my opinio	diste and place n, death occur 29c. LICE	, and due to det the t	City or Town, State)	ner as state	d, cause(a) a	ind manner as stated,

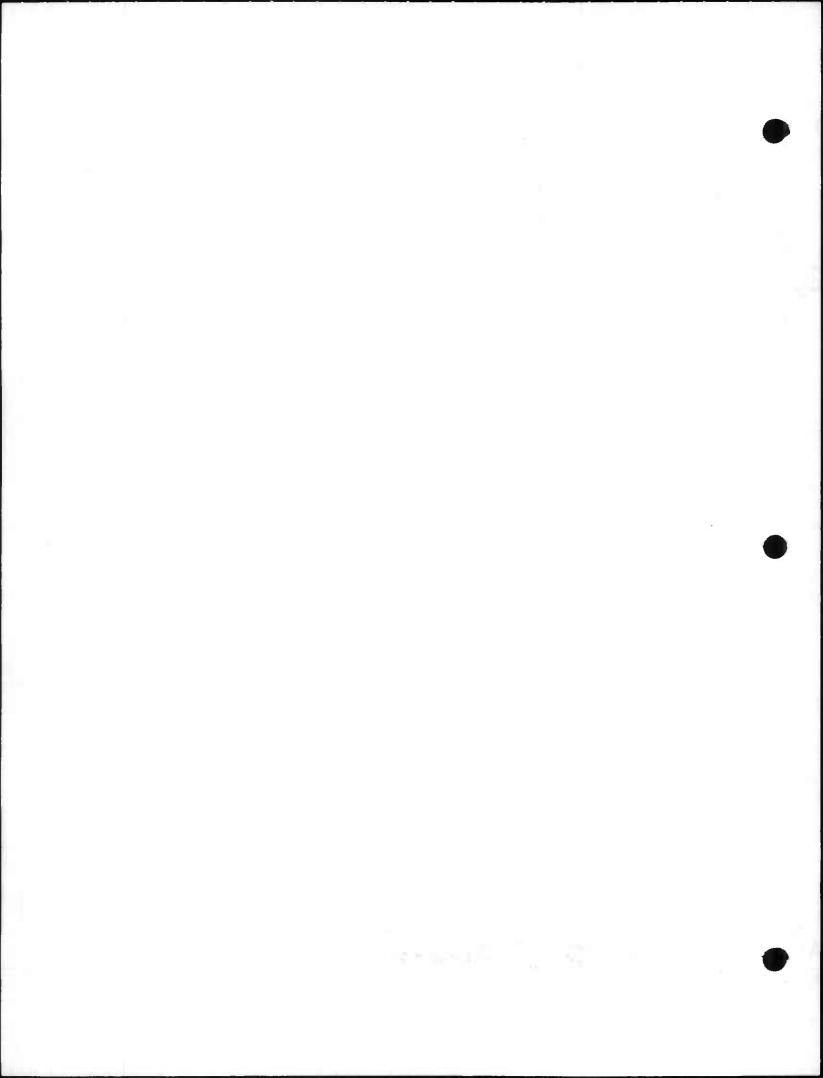
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician 10 THE FUNERAL DIRECTIOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trail be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. **BALTIMORE, MARYLAND 21215-0020** 

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

APR - 9 1993

Julie Deviden Bandon

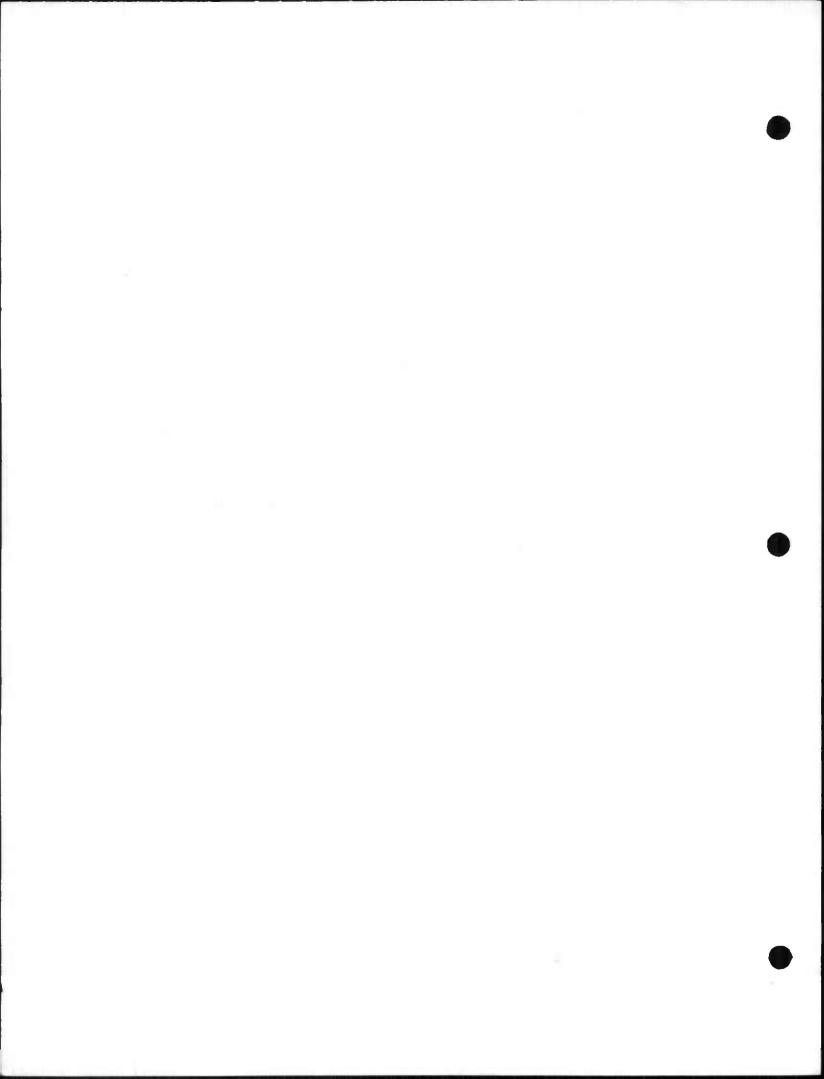


BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

ained by the hospital or attending physician.	should be detached for use as the burial-transit permit. Pages 1.2.3 should		iffed at once.
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1 2 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once,

	FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL HYGIE		
	1. DECEDENT'S NAME (First, Middle, Last)	BELLE			Direct	2. DATE OF DEATH MONTH	DAY YI	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER		LINEBERO	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8 1993	BIRTHPLACE (State or Foreign
	215-22-1592	1 □ M 2 □XF	89 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) 05-09-19	03	PA.
DIRECTOR	99. FACILITY NAME (If not institution, give: NORTH ARUNDEL CO		ENTER		BURNIE	EATH	ANNE	ARUNDEL
EG	RESIDENCE OF DECEDENT 10a, STATE 10b. COUNT	Υ	toc. CITY	, TOWN OR LOCAT	ION			10d, INSIDE CITY
		E ARUNDEL			RSVILLE			LIMITS?
FUNERAL	100. STREET AND NUMBER 8318 ELVATON ROA	D		10f	21108		U.S.	OF WHAT COUNTRY?
FUN	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER II FORCES? 1 YES	2 XNO	If yes, spi	ecify Cuban, Mexica	NIC ORIGIN? (Specify Youn, Puerto Rican, etc.)	14.	RACE — American Indian, Black, White, etc.
р Вү	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D			2X NO Specif	fy:		Specify: WHITE
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	JCATION e completed) College (1-4 or 5+)	16a. DECEDENT'S (Give kind of w life. Do NOT use	rork done during mos	ON st of working	16b, KIND OF BI	JSINESS/INDUST	TRY
MP	8	NONE	PACKAGI	NG		McCORM]	CK SPI	CE
	17. FATNER'S NAME (First, Middle, Linet)	mm *1 *1 *1.				AME (First, Middle, Melde		
BE	JOSEPH S'  190. INFORMANT'S NAME (Type/Print)	TEFFEY		22/2016	MARGARE			
2	LENA M. HIRE	S				Route Number, City or To GLEN BURN		RYLAND 21060
	20e. METHOD OF DISPOSITION 1 X Surlet 2 □ Cremation 3 □ Rem	noval from State 20b	. PLACE AND DATE O	F DISPOSITION (Na		DATE 20c, L	OCATION — City	or Town, State
	4 Donation 5 Other (Specify)		EDAR HIL	L CEMETI	ERY ID ADDRESS OF FA	1 3 3 3 1		MARYLAND
	·Xha	Lang.				SINGLE		NERAL HOME NIE, MD. 21061
	23. PART . Enter the diseases, or shock, or heart failure.  IMMEDIATE CAUSE Kinal disease or condition resulting in death)	Congec	the deeth. Do not line.	Heart	100	4	piratory arrest	Approximsta Interval Between Onset and Death
ATION	Sequentielly list conditions, if any, leading to immediata cause. Enter UNDERLYING	. 0	CONSEQUENCE OF					
CERTIFICATION	CAUSE (Disesse Dr injury that initiated events resulting in death) LAST	c. DUE TO (OR AS A	CONSEQUENCE OF	):				
AL C	PART ii. Other significant condition	ns contributing to death b	ut not resulting in	n the underlying	ceuse given in	Part I. 24a. WAS AI		24b. WERE AUTOPSY FINDINGS
MEDIC	Chronic Ati	rial fil	rella	ton		1 □ YES	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
M.	Anemia	- 6 -	Da	1				1 HES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	7.5	venou	26. PL	ACE OF DEATH (Ch	eck only one)		
Sic	EXAMINER?	HOSPITAL: 1   Inpatient 2   ER/Outp	atlent 3 🗆 DOA	OTHER:		8 Other (Specify)		
	27. MANNER OF DEATN  1 Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	OF 28c. INJU	JRY AT	28d. DESCRIBE NOW	INJURY OCCUR	ED
D BY	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm, st			281. LOCATION (Street City or Town, State	end Number or F	Rural Route Number,
	4 Nomicide datermined							
COMPLETED	(Check only T CERTIFYING PRYS	ICIAN: To the best of my knowless: On the tests of examination						ruse(e) end manner ee stated.
TO BE (	296. SIGNATURE AND TITLE OF CONTIFIES	240	MD		29c. LICENSE NUM		29d. DATE SIG	GNED (Month, Day, Year)  11-8-93
F	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	ATN (ITEM 27) (Type,	Print)			- 0	
	31. DATATIVED (1) 9 DA 91913 Julia Davidor Mondete							



_	-00	1 - STATE REGISTRAR	STATE UP MA			ICATE				MENIAL	REG. NO.	Ł		
		1. DECEDENT'S NAME (First, Middle, Last) THOMAS MCDAI	NIELS IV							2. DATE O	F DEATH	1993	YEAR 1	TIME OF DEATH
		4. SOCIAL SECURITY NUMBER	5. SEX 6	AGE (In yrs. lest		IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF	_			ACE (State or Foreign
should		218-27-4127  9a. FACILITY NAME (If not institution, give atm	71	3	YRS.	96. CITY,	TOWN C	R LOCATI	ON OF DEA		-90	9c. COUNT	M L	
2, 3 si	TOR	THE JOHNS HOPKINS	HOSPITAL			BAL	TIMO	RE (	CITY					
	DIRECTOR	10a. STATE 10b. COUNTY				y, town o								Dd. INSIDE CITY LIMITS?  (T) YES 2   NO
	FUNERAL	100. STREET AND NUMBER 405 S. Beechf	ield Av	e. Apt	. E		101	212		-		. 4 /		AT COUNTRY?
0000	BY FUN	11. MARITAL STATUS  1 Never Married 2 Married  3 Nidowed 4 Divorced	12. WAS DECEDENT I FORCES? 1 I IF YES, GIVE WAR	YES 2 NO		13. V	yes, sp	ENDENT ( ecify, Cube 2 NO	OF HISPANI In, Mexican Specify:	IC ORIGIN? I, Puerto Ric	(Specify Yes	or No-	Black, V Specify:	American Indian, White, etc.
2	0	15. DECEOENT'S EDUCA (Specify only highest grade of		(Giv	e kind of	USUAL OC	CUPATIO	ON st of worldi	na	16b. F	UNO OF BUS	I BINESS/INDU		lack
	COMPLET	Elementary/Secondary (0-12) CHILD	College (1-4 or 5 +)	We.	ILD	se retired.)	00.00							
YILA by the last one art one	BE CO	17. FATHER'S NAME (First, Middle, Last) Thomas McDanie	III.		-12.					Dard	ddle, Maiden den	Sumame)		
MARYLA retained by the 5 should be det notified at on	TO B	19a. INFORMANT'S NAME (Type/Print) Thomas McDanie	1 111.	19b.	MAILING 05	S. B	(Street a	nd Number	or Rural A	Ave.	City or Town	n, State, Zip (	alti	229 imore,MD
BALTIMORE, nours after death. Page 6 mey be ed in by the funeral director, page or removal.		20e, METHOD OF DISPOSITION 1 (A Burlel 2 Cremetion 3 Remont		20b. PLACE AI cemetery, crem AYDU	ND DATE	OF DISPOSI	TION /Na	me of	Park	OATE	20c. LO	CATION — C	ity or Town	, State
ALTIMOF death. Page 6 m funeral director, examiner mus		21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE /	AIDU	tus			_	SS OF FAC		INIL	ucus	, 111	
BAL ter death the fun oval.		Kinette	15-40	res							-			RTH AVE.
E4 hours after filled in by th on, or remova		23. PART I. Enter the diseases, or co shock, or heart failure. L	mplications that distance that only one cause	caused the des	th. Do i	not enter	the mo	de of dy	lng, such	as cardia	c or respi	ratory arre	at,	Approximate Interval Between Onset and Death
42 min min		disease or condition resulting in death)	BLEED DUE TO (0	ING	D UENCE O	IATH	ES	S						5 days
68 and and bur	CATION	Sequentially list conditions, if any, leading to immediate	PULMO DUE TO (O	HAS A CONSECU		MOR	RHI	AGE						5 days
O. BOX errificate be e ng physician giene prior to	FICAT	CAUSE (Disease or injury	DUF TO (O	R AS A CONSEQU	IENCE O	EI.								0
P.O. E eath certifica attending phratal Hygiene Y, or other	CERTIFI	that initiated eventa resulting in death) LAST				.,.								
ADS true d by the of Mer	- 4	PART II. Other significant conditions	contributing to de	eath but not re	aulting	in the une	derlying	cause	given in F	- 1	4a, WAS AN PERFOR	MED?	AV	ERE AUTOPSY FINDINGS MILABLE PRIOR TO
Signe Signe Health	MEDICAL			-						_   '	YES 2	□ NO	Of	OMPLETION OF CAUSE F DEATH?
2 0 4 -		25. WAS CASE REFERRED TO MEDICAL					26 01	ACE OF D	EATH /Ch-	ck only one)				
F 在 在 在 是	YSICIAN	1 TES 2 NO	HOSPITAL:	ER/Outpatient 3	DOA	OTHER 4 Nurs	:	15/45		B C Other (				
の計画を	У РНУ	27. MANNER OF SEATN  1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF IN (Month, Day,		28b. TIM	IE OF JURY M		URY AT RK? 'ES 2		28d. DEŞC	RIBE NOW II	NJURY OCCL	JRED	
ASION SERVICE	TED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF a building, at	INJURY — At horr c. (Specify)	o, farm,	street, facto	ery, office				TON (Street a Town, State)	and Number o	r Rural Rout	e Number,
	COMPLE	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER												nd manner as stated.
TO THE HOSP TO THE FUNE be filed within	BE CC	296. SKANA UNE NO TITLE OF CHATIFIER	J MILL	FR. MI	)				ENSE NUM				SIGNED (M	onth, Day, Year)
6 6 % ₹	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF DEATH (ITEM	27) (Type	, Print)		17	. D	~	110	DI CO	4 -	10
_		31. DATE FILED MORTH DOWN BOND 1993	32. REDISTRAR	SIGNATURE		\$100	TE	r1	7	HEL	וודונ	RICS	>	
		APR 09 1993	guha D	s signature buidson A	andel	2								

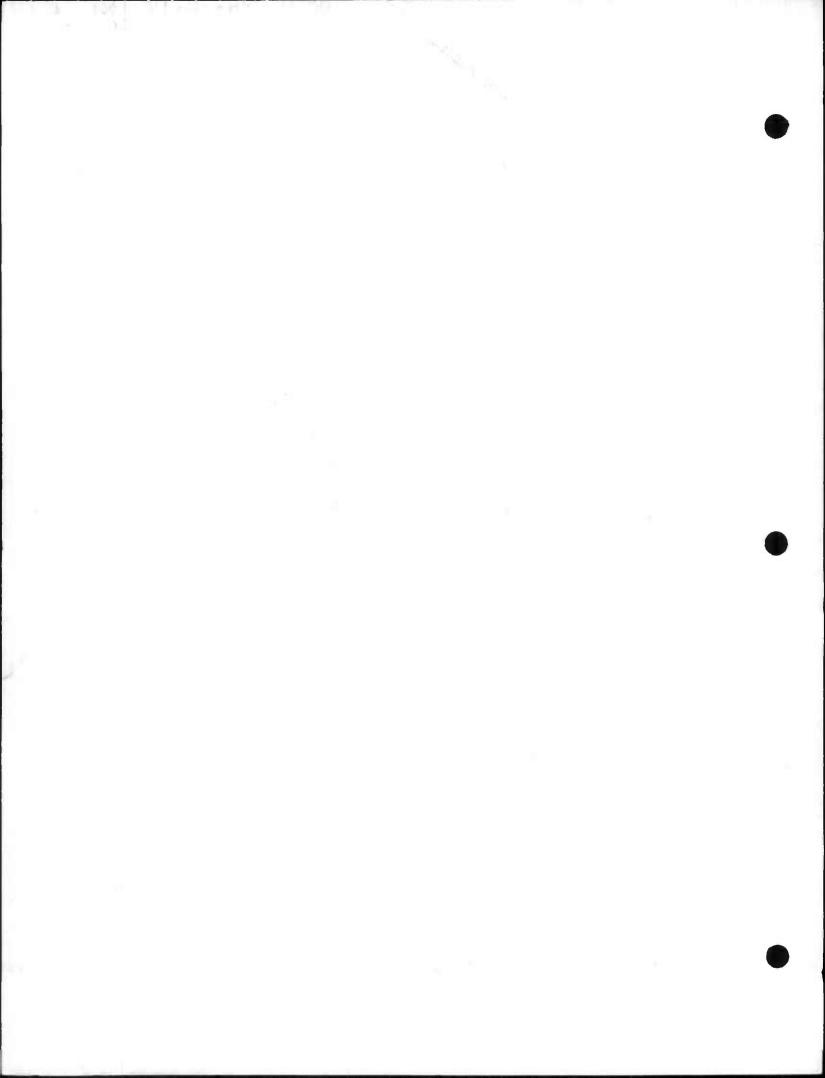
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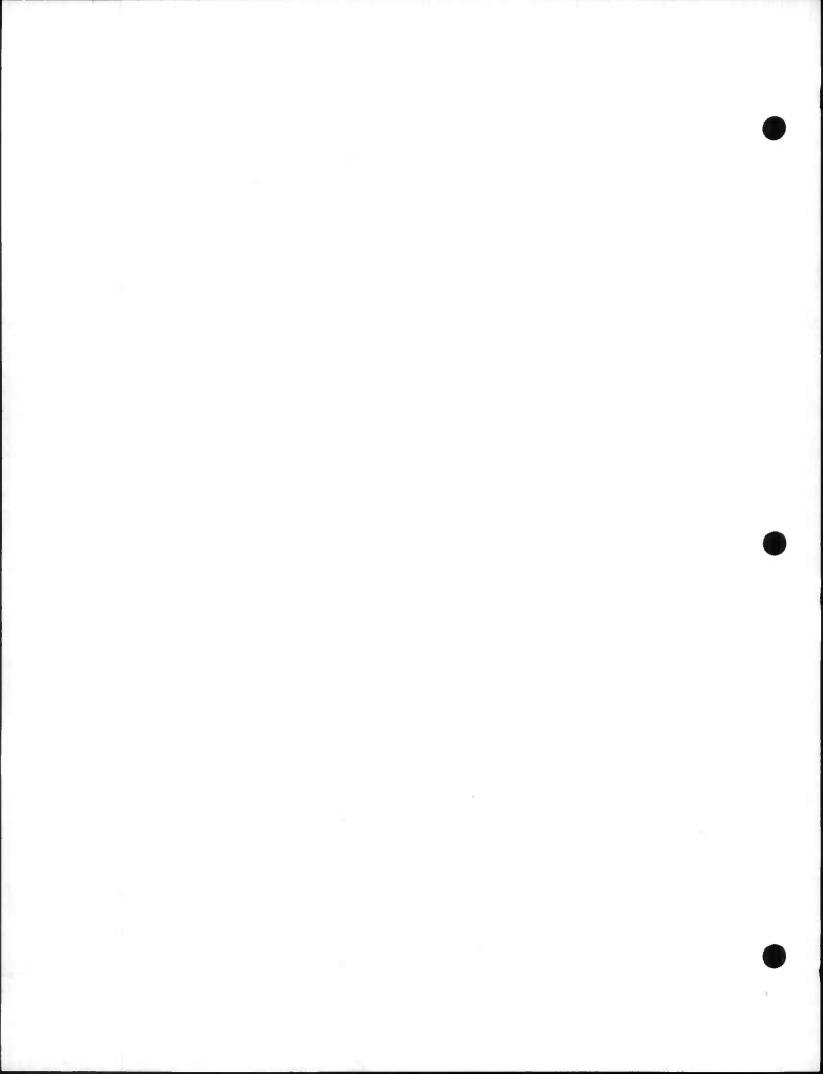
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4/06/93	193 0	9975

	1 - STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAR ERTIF					MENTAL	HYGIEN REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, La SHIRLEY EL	IZABETH	MCKIVER	2					2. DATE C	IL 6,	1993	YEAR	3. TIME OF DEATH 10:02P M
	4. SOCIAL SECURITY NUMBER 216 - 42 - 2371	5. SEX 1	6. AGE (In yrs. les		IF UNDER	1 YEAR DAYS	# UNDER	24 HRS, MIN.		F BIRTH Day, Year)		Countr	PLACE (State or Foreign V)
OR	9a. FACILITY NAME (If not institution, gi	PKINS HOSE	PITAL		100		I MORE				9c. COUNT	TY OF D	
FUNERAL DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE  10b. COU				Y, TOWN C		ION			-			10d. INSIDE CITY
AL DI	MD 100. STREET AND NUMBER			Bal	time		. ZIP CODE				10e, CITIZ	EN OF W	1 X YES 2 NO
NER/	941 Patterso						212				USA		
8≺	1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	TEVER IN U.S. AR YES 2 XI MAR OR DATES	RMED NO	1	f yes, spe	ENDENT OF	, Maxican	n, Puerto Ri	(Specify Yes can, etc.)	or No—	14. RACE Black Specif	- American Indian, Whita, etc.
BE COMPLETED	15. DECEDENT'S E (Specify only highest gr Elementary/Secondary (0-12)	EDUCATION rade completed)  College (1-4 or 5 d	) (G	CEDENT'S live kind of vi Do NOT us	work done o se retired.)	during mo:	ON st of working	7	16b. i	UND OF BUS	INESS/INDU	STRY	
S	17. FATHER'S NAME (First, Middle, Lest) Bonnie McLea	n								ddle, Maiden S	Surname)		
TO BE	19a. INFORMANT'S NAME (Type/Print)	11	19	b. MAILING	ADDRESS	(Street a			Walk loute Numbe	er r, City or Town	, State, Zip C	Code)	
F	Judy McLean		1 400 400 40	7669	Ror	na (	Ct./	Gler		rnie,			
	1 Constition 2 Cremetton 3 Removal from State Consider (Specify) Commence of the (Specify) Dundalk, MD												
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE			22.1	NAME AN	D AOORES	S OF FAC	YTUK				ORTH AVE.
CERTIFICATION	23. PART i. Enter the diseases, shock, or heart failured in the failure in the fa	a. Sep  DUE TO  DUE TO  C. ACL	se on eech line	ouence of	PI: B	OW	el						Approximate Interval Between Onset and Death 12 hours
PHYSICIAN: MEDICAL C	PART II. Other algorificant condit  Hyperten	iona contributing to	death but not a	reaulting (	n the un	derlying	cause g	iven in F		PERFORI	AED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 □ VES 2 □ NO	HOSPITAL:	FR/Outpetlant 3	□ noa	OTHER	1:			ck only one)				
	27. MANNER OF DEATH	28a. DATE OF (Month, D	INJURY	28b. TIM		28c. INJU	JRY AT RK?		_	RIBE HOW IN	JURY OCCU	REO	
LED BY	2 Accident Investigation 3 Suicide 8 Could not independent detarmined	me, farm, s	treet, facto		ES 2 [		28f. LOCAT	TON (Street ar Town, State)	nd Number o	r Rural A	oute Number,		
COMPLETED		YSICIAN: To the best of INER: On the basis of an											and manner as stated.
TO BE C	29b. SIGNATURE AND TITLE OF CERTIF	MDJ2	8004				29c. LICE						(Month, Day, Year)
	DR. HERER THE J	NHO COMPLETED CAUS OHNS HOPKI	NS HOSP	M 27) (Type, ITAL	Print) 600N	WOL	_FE_S	TREE	ET BA	LTIMOR	RE MD	212	287
	31. DATE FILEO (Month, Day, Year)  32. REGISTRAR'S SIGNATURE  100 1993 Fishe Davidson-Randelle												



BALTIMORE, MARYLAND 21215-0020	PHYSICIAN: The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hospital or attending physician.	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 shou with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or remoral.	t, the medical examinar must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral be filled within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows eny injury, or other traumatic event, the medical examiner must be notified at once.

-	TIEGIOTTENT		0-11111	ONIE	AL DEALL	1	REG. NO.				
Į.	1. DECEDENT'S NAME (First, Middle, Lest)	MONTH DAY YEAR									
	4. SOCIAL SECURITY NUMBER 5. SEX		rs. fast birthday)		AR IF UNDER 24	Apr		1993			
	215-32-6999 A 1 = M 2 DX			IF UNDER 1 YE			e of siletting the or sile 30 19		BIRTHPLACE (State or Foreign Country) Maryland		
	9a. FACILITY NAME (If not institution, give street and number)			June 30 1904 Mary							
5	Good Samaritan Hospi			Baltimore City							
DIRECTOR	RESIDENCE OF DECEDENT										
빌	10a. STATE 10b. COUNTY		10c, CITY	, TOWN OR L		10d. INSIDE CITY LIMITS?					
	Maryland 10s, STREET AND NUMBER			Bá	ltimore	City			1 X YES 2 NO		
FUNERAL	1701 E Belvede	re Aven	ue		10f. ZIP CODE	21239		n of what country? .ted States			
5		DENT EVER IN U.		13. WAS	DECENDENT OF	NISPANIC ORIG	IN? (Specify Yea		I. RACE — American Indian.		
20		1 🔲 YES : :		If yes	, specify Cuban, YES 2 💢 NO	Mexican, Puerte	Rican, etc.)		Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed)  16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working								STRY			
7.6	Elementary/Secondary (0-12) College (1-4 or 5+)  9  College (1-4 or 5+) Homemaker										
Homemaker  17. FATHER'S NAME (First, Middle, Lest)  18. MOTHER'S NAME (First, Middle, Maiden Surname)											
John Detorie Pasqualina Matrangol  196. INFORMANT'S NAME (Type/Print)  Jerome R. Muffoletto 196. MAILING ADDRESS (Street and Number or Rural Rouse Number, City or Town, State, Zip Code)  4602 Arabia Ave. Baltimore, Maryland								jola			
ì	20e. METHOD OF DISPOSITION  1 X Burial 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify)	20b. PL cemete	ACE AND DATE OF 191, Cremetory or off	er place) dral (	Cem. 4	/12/93	DATE 20c. LOCATION — City or Town, State 2/93 Baltimore Marylan				
	1   QL Burlai 2   Cremation 3   Removal from State   Camplery, crematory or other place)   Cem. 4/12/93   Baltimore   Maltin										
	> nulton Ky	roll.	L.				Inc. 5	305 H	larford Road		
•	23. PART I. Enter the diseases, or complications shock, or heart feiture. List only one IMMEDIATE CAUSE (Final disease or condition resulting in death)	catist on each	line.	enter the	mode of dying	, such as ca	rdiac or respin	atory arres	t, Approximate interval Between Onset and Death		
HILLAHON	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	TO (OR AS A CO	ONSEQUENCE OF								
CERT	that initiated events resulting in death) LAST	10 (01 22 2 00	ASECUENCE OF								
	PART II. Other significant conditions contributing	to deeth but	not resulting in	the under	ying ceuse giv	en in Part i.	24a. WAS AN A		24b. WERE AUTOPSY FINDINGS		
200	COPD						PERFORM		AVAILABLE PRIOR TO COMPLETION OF CAUSE		
U I	Sepsis						1 123 21		OF DEATH?		
2	J										
THISICIAN.	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:				. PLACE OF DEA	TN (Check only	one)		<b>'</b>		
2	1 YES 2 NO 1 Inpution	2 ER/Outpatie		OTHER: 4 - Nursing	Home 5 - Resk	lence 8 🗆 Ott	ner (Specify)				
	1 Netural 5 Pending (Mont	OF INJURY 1. Day, Year)	28b. TIME INJU	IRY	INJURY AT WORK?		EȘCRIBE HOW IN	JURY OCCUP	RED		
On- DI AND OF BUILDING									Rural Route Number,		
COMPLEIED	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the bea										
	one) 2 MEDICAL EXAMINER: On the basis	of examination ar	nd/or investigation	, In my opinic	n, death occured	at the time, da	te and place, and	due to the c	ause(e) end manner ee stated.		
4	296. SIGNATURE AND TITLE OF CERTIFIER  M  M	·D . (	Irtan	)	29c, LICENS	SE NUMBER		29d. DATE S	IGNED (Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED O				CALLA	4'>			1-110		
ļ	VIRGILIO M. PGUILKI		, M		Jun	8					
	APR 09 1993 Julia Suri	Con-Hand									



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or after	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use be filled within 72 hours after death with the State Debt, of Health and Mental Hyolene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
END	R. A	-
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30. NAME AND ADDRESS OF PERSON WHO COM

(00 N. Wife st.

31. DATE FILED (Morith, Day, Year)

APR 0 9 1993

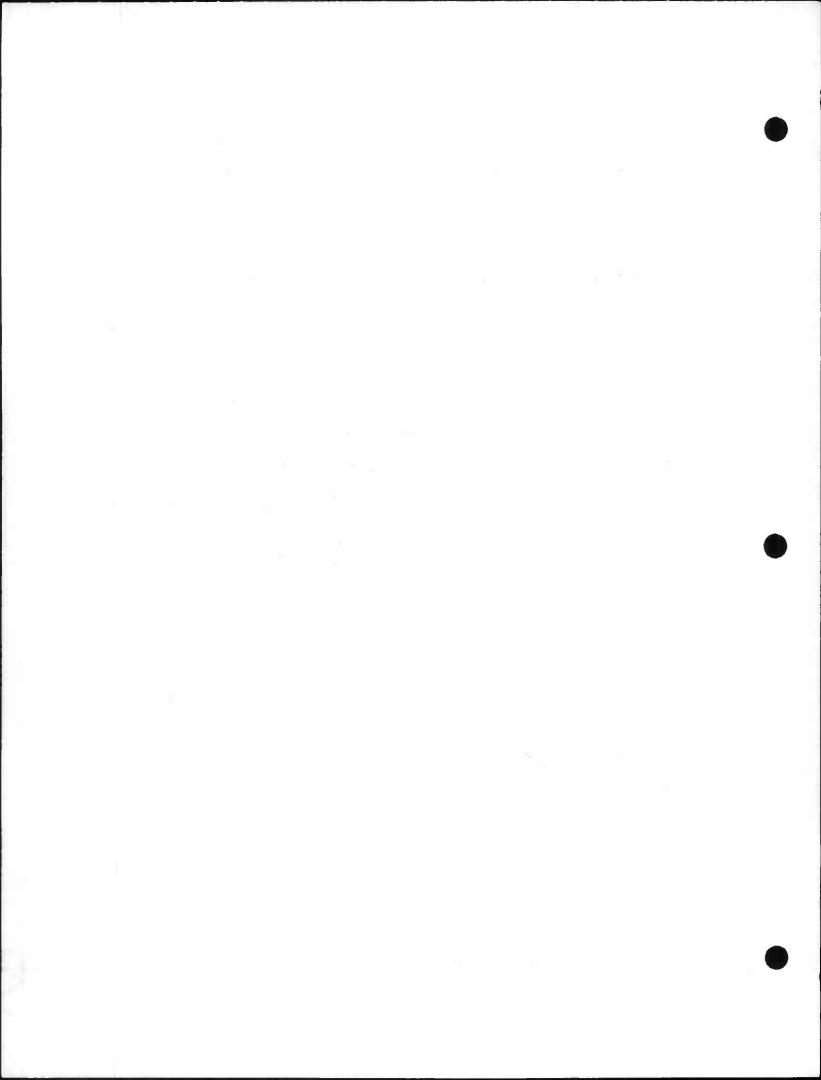
	FOR STATE REGISTRAR	STATE OF MARYLA		MENT OF HEALTH AND CATE OF DEATH	MENTAL HYGIE		3 09977		
	1. DECEDENT'S NAME (First, Middle, Last) ROWENA ROSS	OGILVI			2. DATE OF DEATH MONTH 5,	<b>1</b> 993	3. TIME OF DEATH 3:35 A M		
	4. SOCIAL SECURITY NUMBER  165-20-1283  9a. FACILITY NAME (# not institution, give s	5. SEX 6. AGE (In	IF UNDER 1 YEAR IF UNDER 24 HRS ONTHS DAYS HOURS MIN.  Ib. CITY, TOWN OR LOCATION OF	Dec. 23, 1924 Wales					
тов	THE JOHNS HOPKI		DEATH /	BALT:	IMORE CITY				
DIRECTOR		imore		arkton		10d, INSIDE CITY LIMITS? 1 YES 2 NO			
BY FUNERAL	17305 Pretty Boy				L120	10g. CITIZEN OF WHAT COUNTRY? USA			
	1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN I FORCES? 1 TYES IF YES, GIVE WAR OR DAT	2 X NO	13. WAS DECENDENT OF HISP If yes, specify Cuben, Max 1 YES 2 NO Spe	ican, Puerlo Rican, etc.)	es or No— 14.	. RACE — American Indian, Black, White, etc. Specify:		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	(Give kind of wor life. Do NOT use i	BUAL OCCUPATION k done during most of working witred.)	16b. KIND OF BI	USINESS/INDUS	_White		
COMPI	17. FATHER'S NAME (First, Middle, Last)	4+	Tea	cher 18. MOTHER'S	NAME (First, Middle, Maide	Educa:	tion		
TO BE	David Ros	ser	19b. MAILING AI	DDRESS (Street and Number or Run	izabeth M.  Bl Route Number, City or To		rde)		
-	Clarence James Og	20h. F	LACEANDDATEOE	Pretty Boy Da	DATE 20c II	OCATION CIN			
	4 Donation 6 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LIC	Du Du	laney Va	11ey Mem.Garde	ens 4/8/93	Timon	ium, MD		
	Martin D.		the death. Do not	Lemmon-Mitch	a Rd. Tim	onium.	MD 21093		
	shock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one cause on eac	th line.	al Infancti		onatory sneat	Interval Between Onset and Death		
CATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING								
CERTIFICATION	CAUSE (Disesse or injury that initiated events resulting in death) LAST	DUE TO (OR AS A C	CONSEQUENCE OF):						
PHYSICIAN: MEDICAL	PART II. Other significant condition	s contributing to death but	not resulting in	the underlying csuse given i		AMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?  1 YES 2 NO		
ICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HQSPITAL:		26. PLACE OF DEATH (C					
ВУ РНУ	27. MANNER OF DEATH  1 Haturel 5 Pending Investigation	1 Propertient 2 ER/Outpat  26e. DATE OF INJURY (Month, Day, Year)	28b. TIME C		e 6 ☐ Other (Specify)  26d. DE\$CRIBE HOW	INJURY OCCUR	ED		
	3 Suicide 6 Could not be determined	25e. PLACE OF INJURY – building, etc. (Specify	Al home, farm, stre	et, lactory, office	261. LOCATION (Street City or Yown, State		Rural Route Number,		
COMPLETED				it the time, data and place, end di in my opinion, death occured at it			euse(e) and menner se stated.		
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER	ee MD		29c. LICENSE N	UMBER	29d. DATE SI	GNED (Month, Day, Year)		
	30. NAME AND ADDRESS OF PERSON WHO			ini)	ZM Oncor	2124	- Pathy Leaning		

OMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

TOWNS HOLLY HUSDITOL

102, REGISTRAR'S SIGNATURE

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, MARYLAND 21215-0020	Pane 6 may be retained by the hospital or attending physician
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The live recovers that the death of this processor within 24 hours after death, Pa	TO THE FUNERAL DIRECTOR. After this certificate has been sepred by the attraction paragraphs and characteristic the funeral of the filed within 72 hours after death with the State Deat, of Health and Mental Hospita principle at temporal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examine
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93 09978 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR OL50N Mildred 0855 APRIL 1993 8. BIRTHPLACE (State or Foreign Country) 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. 1 M 2 F 323 16 1695 84 1908 Oct 13 New York 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Wicomico Salisbury 1 TYES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1020 Fairground Dr. Apt.6 21801 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO 1 Never Married 2 Married 1 TES 2 NO Specify: ΒY Specify 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade compl Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) be notified at William Grenschow BE Maude Watkins 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21801 2 John Olson 020 Fairground Dr. Apt. 6, Salisbury, 20s, METHOD OF DISPOSITION

1 🖰 Burlal 2 🗆 Cremation 3 🗆 Removal from State

4 🗆 Donation 5 🗆 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Park Cemetery Acacia North Tonawanda, NY 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY Ives-Pearson Funeral Home Arlington.Va.22201 medical 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart fallure. List only one ceuse on each line. interval Betw IMMEDIATE CAUSE (Final Onset and Death # disease or condition Respusing other traumatic event, resulting in death) DUE TO JOR AS A CONSEQUENCE OF gulnoray disease listra CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING QUE TO (OR AS A CONSEQUENCE OF) CAUSE (Disease or injury that initiated events resulting in death) LAST 10 shows any injury. PART II. Other aignificant conditions contributing to deeth but not reaulting in the underlying ceuse given in Part i. 24b, WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 1 YES 2 NO OF DEATH? 1 YES 2 NO PHYSICIAN: tem 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 TYES NO Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 NgResidence 6 ☐ Other (Specify) feath with the S marked, or i 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Netural
2 Accident 5 Pending 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 89 6 Could not be COMPLETED item 28 4 Nomicide 29a. CERTIFIER

Chart call

CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29d. DATE SIGNED (Month, Day. 29c. LICENSE NUMBER BE 1928 Kaals 6

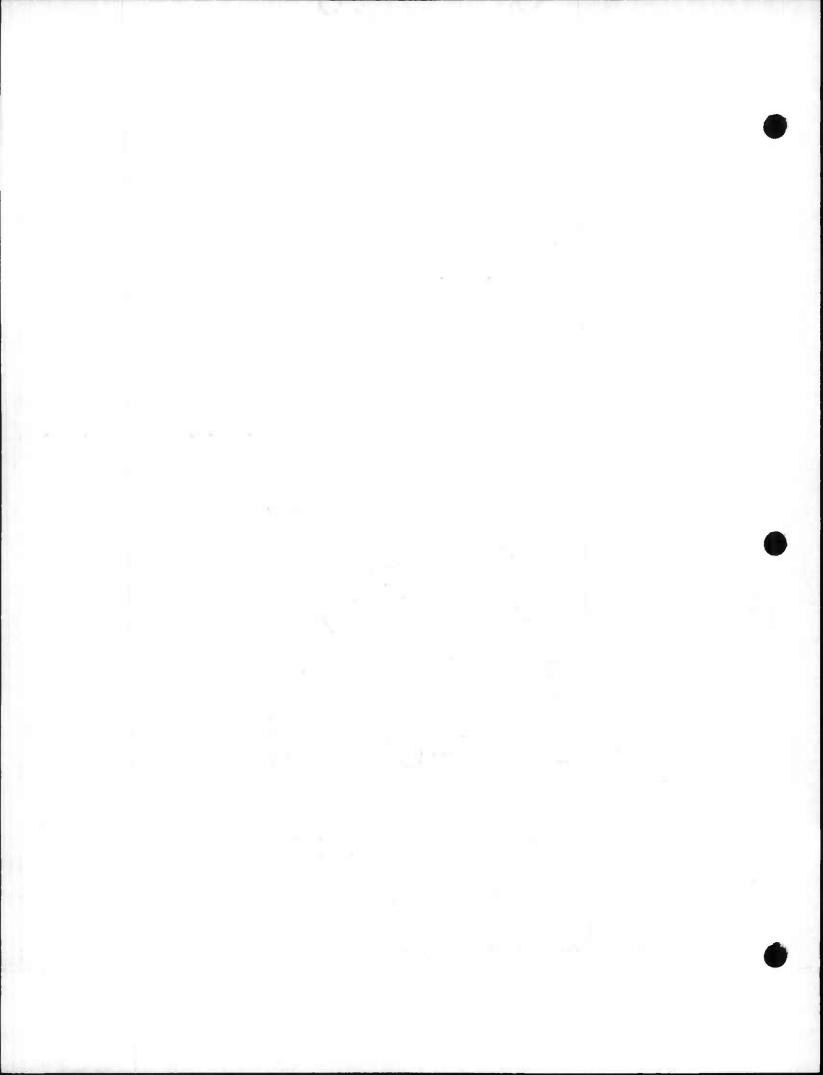
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ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

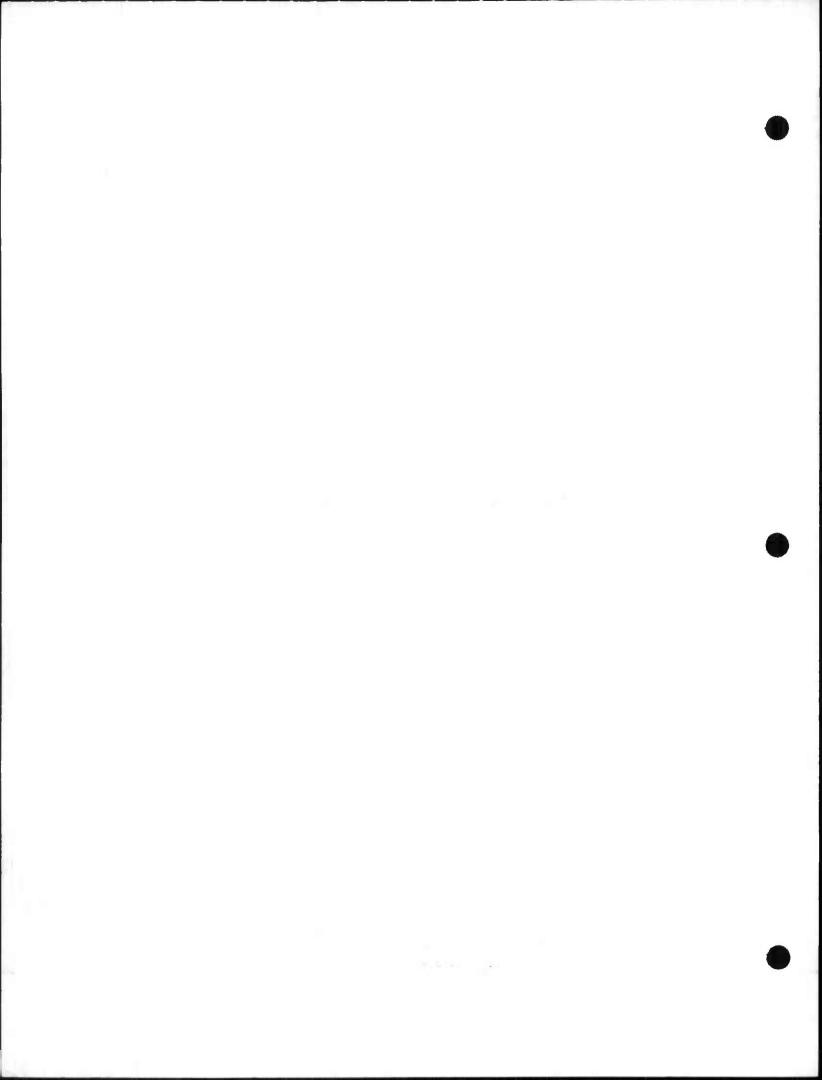
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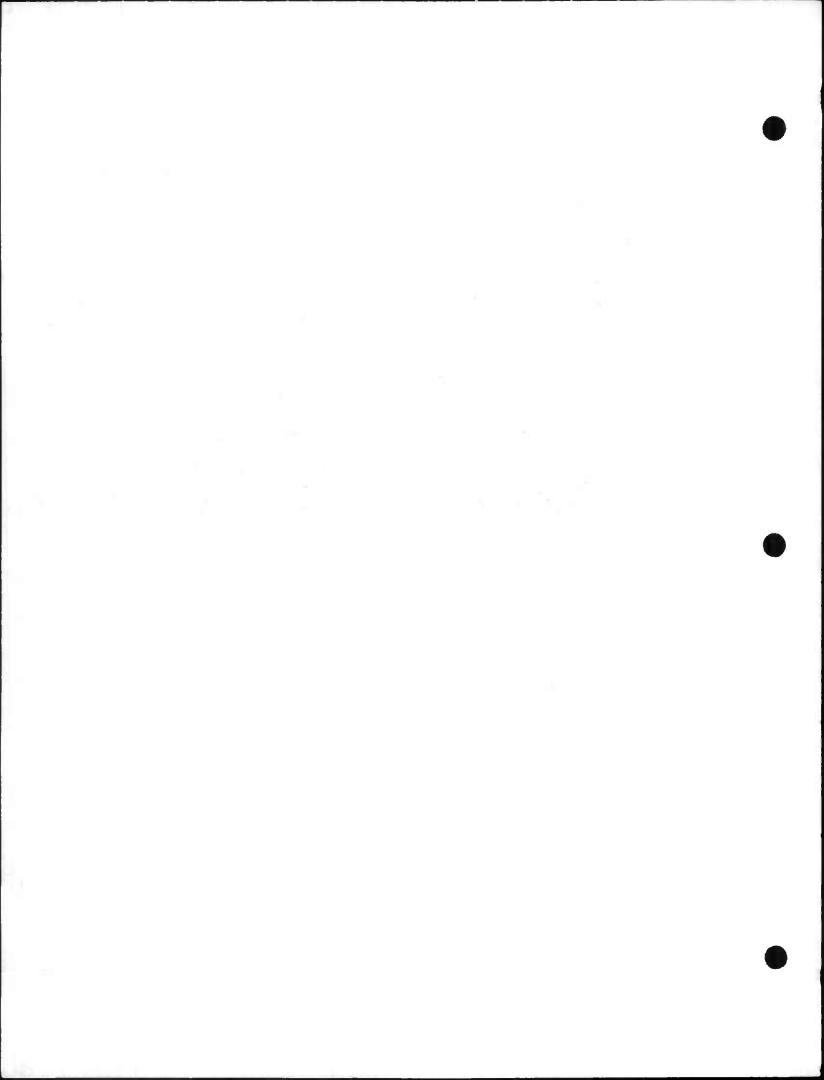
fing physician.	the burial-transit permit. Pages 1, 2, 3 should	
10 THE HOSPIAL DRIVENING PHYSICIAN: THE IAW requires that the death certificate be emounted within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely find in by the funeral director, page 5 should be detached for use as the burial-branet permit. Pages 1, be filed within 72 hours after death with the State Dest, of Health and Mental Hydiese prior to burial, complete, or removal.	or Item 23 shows any injury, or other traumatic event.

						9	33 09979		
	1 - STATE OF MARYLA	AND / DEPARTA	MENT OF HE	ALTH AND N		GIENE G. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DE	ATH	3. TIME OF DEATH		
	MELVIN E DWIN	PF	ANNENST	EIN, SR	04	07	93 07:43 AM M		
	471-24-8403 1 RM 2 DF 64	YRS.	ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.			6. BIRTHPLACE (State or Foreign Country) MINNESOTA		
OB	9a. FACILITY NAME (If not institution, give street and number)  NORTH ARUNDEL HOSPITAL ASSOC	BURNIE	АТН	9c. CO	A.A. COUNTY				
5	10s. STATE 10b. COUNTY	- 1	10d. INSIDE CITY						
AL DIRECTOR	MARYLAND ANNE ARUNDEL		BURNIE	LIM					
FUNERAL	8918 PARK SOUTH DRIVE		2	1061		U	J.S.A.		
ВУ	12. WAS DECEDENT EVER IN FORCES? 1 ♥ YES IF YES, GIVE WAS ON & VIE KOREAN & VIE	2 ND	If yes, speci	IDENT OF HISPANI Ify Cuban, Maxican XND Specify:	C ORIGIN? (Spe , Puarto Rican,	cify Yes or No-	14. RACE — American Indian, Bleck, Whita, etc. Specify: WHITE		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary(Secondary (9-12)  Cottege (1-4 or 5 +)	16a. DECEDENT'S US (Give kind of work life. Do NOT use n	done during most of	of working	16b. KIND	OF BUSINESS/IN	IDUSTRY		
鱼	10 NONE	SECURITY			WE	STINGHO	DUSE		
8	17, FATHER'S NAME (First, Africia, Last)		1	18. MOTHER'S NAM	IE (First, Middle,	Maiden Surname)			
BE	JOHN PFANNENSTEIN			MARGARI	ET PHIL	LIPPI			
70	DONNA M. PFANNENSTEIN			Number or Rural Ro TH DRIVE			E, MD 21061		
	20b. METHOD OF DISPOSITION  1 W Burlal 2 Cremation 3 Removal from State  AD Donation 5 Other (Specify)  20b. PLACEAND DATE OF DISPOSITION (Name of MARY LAND VETERANS CEMETERY 4-9 CROWNSVILLE, MD								
	21. SIGNATURE OF PUNERAL SERVICE LICENSEE	/	SINGLE	ADDRESS OF FACE	ERAL HO	ME			
$\vdash$	The war O meson		1 SECO	ND AVE.	S.W.	GLEN BU	JRNIE, MD 21061		
TION	- gran	consequence or:	Twee	de	Them		Approximata interval Between Onset and Death		
SERTIFICATION	ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (DR AS A CONSEDUENCE DF):								
I: MEDICAL C	PART, If Other significent conditions contributing to death but not resulting in the underlying cause given in Part i.  24a. WAS AN AUTOPSY PERFORMED?  1 YES 2 NO  24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO								
A	25. WAS CASE REFERRED TO MEDICAL		26. PLAC	E OF DEATH (Chec	k only one)				
PHYSICIAN:	EXAMINER?  1 YES 2 DID  HOSPITAL:  Inputient 2 ER/Output		THER:	5 Residence 6		(fv)			
£	27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year)	28b. TIME O	F 28c. INJUR	Y AT		HOW INJURY OC	CCURED		
BY	Nefural 5 Pending (MORII, Day, 1987)  2 Accident Investigation	INSON,		2 ND					
9	3 Suicide 6 Could not be determined  28a. PLACE OF INJURY — At home, farm, street, tactory, offica building, stc. (Specify)  28a. PLACE OF INJURY — At home, farm, street, tactory, offica City or Town, State)								
COMPLET	29a. CERTIFIER (Check only one) PHYSICIAN: To the best of my knowle one) MEDICAL EXAMINER: On the best of axemination								
TO BE C	29h SHEMATOROGAN TITLE OF CENTERED AND AND AND AND AND AND AND AND AND AN	lim	21	Se. LICENSE NUMB			TE SIGNED (Month, Day, Year)		
	HILARY T. O'HERLIHY, M.D./32	/		, SUITE	208/GL	EN BURN	IIE, MARYLAND 210		
	APR 09 1993								



STATE	OF MARYLAND / DEPARTMENT	OF HEALT	H AND	MENTAL	HYGIENE
	CERTIFICATE	OF DE	ATH		REG NO

		1 - FOR STATE OF MARYLAND / CE	DEPARTMENT OF HEALTH AND	MENTAL HYGIENE REG. NO.							
			QUEEN.	2 DATE OF OFATH	3. TIME OF DEATH						
pin		4. SOCIAL SECURITY NUMBER  5. SEX  8. AGE (In yrs. last)  9. GCULTY NAME (If the last) to the last of	YRS. MONTHS DAYS HOURS MIN.	(Mgrtp. Day, Joan) 26	B. BIRTHPLACE (State or Foreign Country) Sever N, Md.						
1, 2, 3 should	CTOR	96. FACILITY NAME (If for institution, give speet and number)  96. CITY, TOWN OR LOCATION OF DEATH  96. COUNTY OF DEATH  96. COUNTY OF DEATH  96. COUNTY OF DEATH  96. COUNTY OF DEATH									
permit. Pages	L DIRECTOR	10a. STATE 10b. COUNTY	10c. CITY, TOWN OR LOCATION.		10d. INSIDE CITY LIMITS? 1 - YES 2 NO						
ian. -transit	FUNERAL	10. STREET AND NUMBER  10. STREET AND NUMBER  11. MARITAL STATUS  12. WAS DECEDENT EVER IN U.S. ARI	101. ZIP CODE 2106	0 U.	EN OF WHAT COUNTRY?						
Z1Z15-00Z0 al or attending physician. for use as the burial-trar	D BY FL	1 Never Married 2 Married FORCES? 1 YES 2 N IF YES, GIVE WAR OR DATES		an, Puerto Rican, etc.)	14. RACE — American Indian, Black, Whita, etc. Specify: B/ACK						
	ETE	(Specify only highest grade completed)  (Gh Elementary/Secondary (0-12)  College (1-4 or 5+)	CEDENT'S USUAL OCCUPATION  We kind of work done during most of working  Oo NOT use refired.)  ARE DOUSEMAN	16b. KIND OF BUSINESS/INDU	STRY						
fyLAND f by the hospital d be detached for	BE COMPL	17. FATHER'S NAME (First, Middle, Last)  NAME ON DUCCH	18. MOTHER'S NA	AME (Pirst, Middle, Maken Symathe)							
TE, MARY  ay be retained by  page 5 should be  t be notified at	70	Ruth E. Queen 110	MAILING ADDRESS (Street and Number or Rural	Poute Number, City or Town, State, Zip of	Md. 2/060						
e 6 m		1 Buriel 2 Cremation 3 Removal from State	ND DATE OF DISPOSITION (Name of natory or other place)  SUITE 22. NAME AND ADDRESS OF FA	OATE 20c LOCATION - CH	ty or Jown, Stata						
SAL I		- 11 My Brown	Wm C. Brown	Comm. F.H. 1206	W. North Aus						
of 60, and within 24 hours after ompletely filled in by the cremation, or remover event, the medical		23. PART I. Enter the disesses, or complications that caused the der shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disesse or condition resulting in death)  DUE TO (OR AS A CONSEC	ENCEPHI	ALDPATH	Interval Between Onset and Death						
h. C. BOX 68 // h certificate be executed anding physician and con Hygiene prior to burial, or other traumatic er	TIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	MA OF LIV	IER,							
signed by the Health and M	MEDICAL	PART II. Other significant conditions contributing to destribut not re HEPATO RENAL SYN ELECTROLYTE DM	PROME, BALANCE.	Part I. 24a. WAS AN AUTOPSY PERFORMED?  1 YES 2 NO	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2 NO						
S b b	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 NO	28. PLACE OF DEATH (Ch								
音音音	ВУ РНУ	27. MANNER OF DEATH  28a. DATE OF INJURY (Month, Day, Year)	DOA   4   Nursing Home 5   Residence	8 Other (Specify)  28d. DE\$CRIBE HOW INJURY OCCU	REO						
2 4 8	G	2 Accident investigation 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At hon building, stc. (Specify)	ne, farm, street, factory, office	281. LOCATION (Street and Number or City or Town, State)	Runti Route Number,						
NEWS CONTRACTOR	COMPLET	29a. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of my knowledge, das medical examiner: On the basis of examination and/or in									
TO THE HOSP TO THE FUNER DE filed within	TO BE C	206. SIGNATURE AND TITLE OF CERTIFIER Chanchakalakafa HO	USELTAFF, AS 2	441614-26 4	SIGNED (Month, Day, Year)						
		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (TEM  CHANDRAKALA RAJA,  31. DATE FILED (Mogif), Don'1649, A D. G. G. 12. RECISTRANSPSIGNATURE.	HARBOR HOS	PITAL CE	ENTER.						
		31. DATE FILED MORIT DOUBLE 1993 32. REGISTRAND SIGNATURE	andere.								

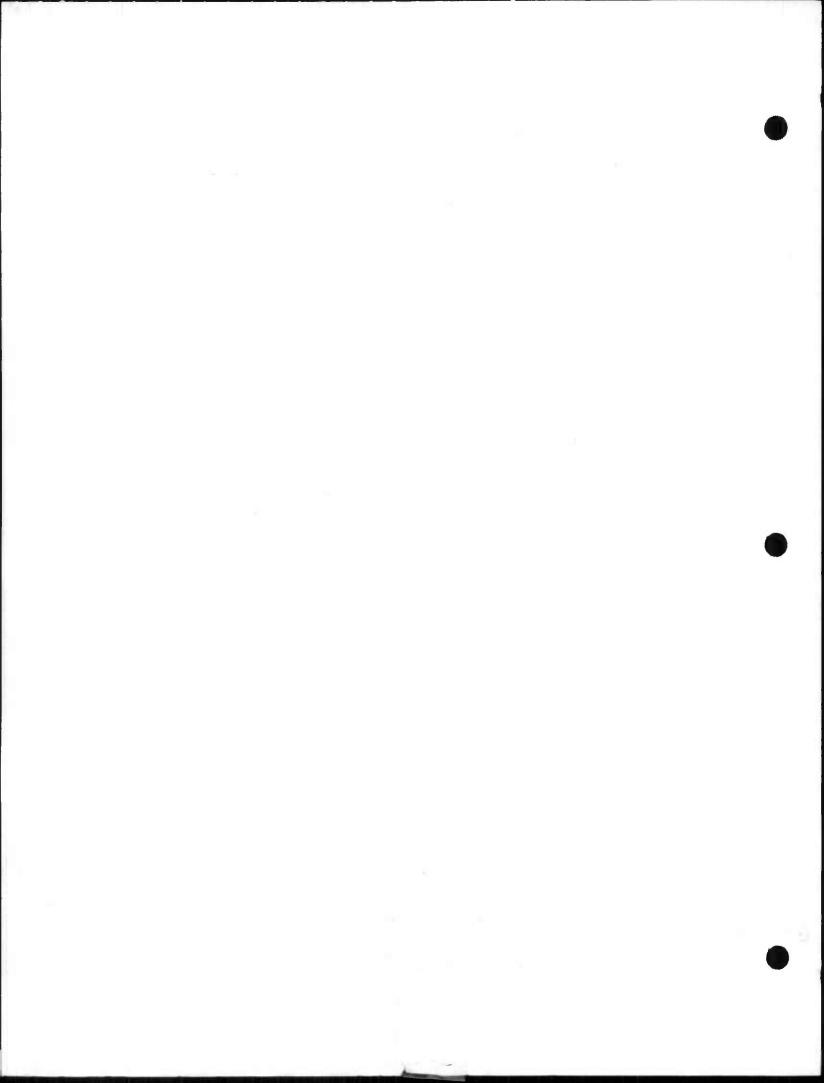


BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL DR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after di	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical ex
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Earl. Wesley Ridgell. Sr. 6:45A 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 219-16-6372 M M 2 | F DAYS HOURS 4-23-1925 Maruland 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH DIRECTOR CHURCH HOSPITAL CORPORATION BALTIMORE CITY RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Dundalk 1 YES 2XX NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10a, CITIZEN OF WHAT COUNTRY 2134 Jasmine Road 21222 United States 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 V YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yes, specify Cuben, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: 14. RACE - American Indian, 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY Specify: White 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. OECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 8th Grado Truck Driver Esskay Meats 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname) te Herbert Ridgell Gertrude Susan Mullen notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ACORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Clara M. Ridaell Jasmine Road Dundalk Maruland pe 20e. METHOD OF DISPOSITION
1 □ Burlal 2 □XCremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION /Name of must DATE 20c. LOCATION -- City or Town, State 4 Donation 5 Other (Specify) Hillton Service Carp 4/9/93 Towson, Maruland examiner THYAL BETTYICE LICENSEE 21. SIGNATURE OF TH 22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximata ahock, or heart feilure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition\_ LIVER METASTA
DUE TO (OR AS A CONSEQUENCE OF 127AST leath with the State Dept, of Health and Mental Hygiene prior to burial, cremat marked, or Item 23 shows any Injury, or other traumatic event, it resulting in deeth) PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditiona, OUE TO (OR AS A CONSEQUENCE OF): if any, landing to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF OEATH (Check only one) HOSPITAL:
1 Minpatient 2 ER/Outpatient 3 DOA OTHER: 1 - YES 2 NO ne 5 - Residence 6 - Other (Specify) 4 🗆 Nu 27. MANNER OF DEATH 26e. OATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 5 Pending Investigation 1 Netural BY 1 YES 2 NO 2 Accident 26e. PLACE OF INJURY — At home, lerm, street, factory, office building, etc. (Specify) 3 Sulcide after de 28 Is r COMPLETED 6 Could not be determined 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29e. CERTIFIER
1 M CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner se stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month. Day, Year) 14/6/93 22 0 ATAOLLAH F. NAZEMI, M.D. 100 N. BROADWAXY STREET, BALTIMORE MD 21231

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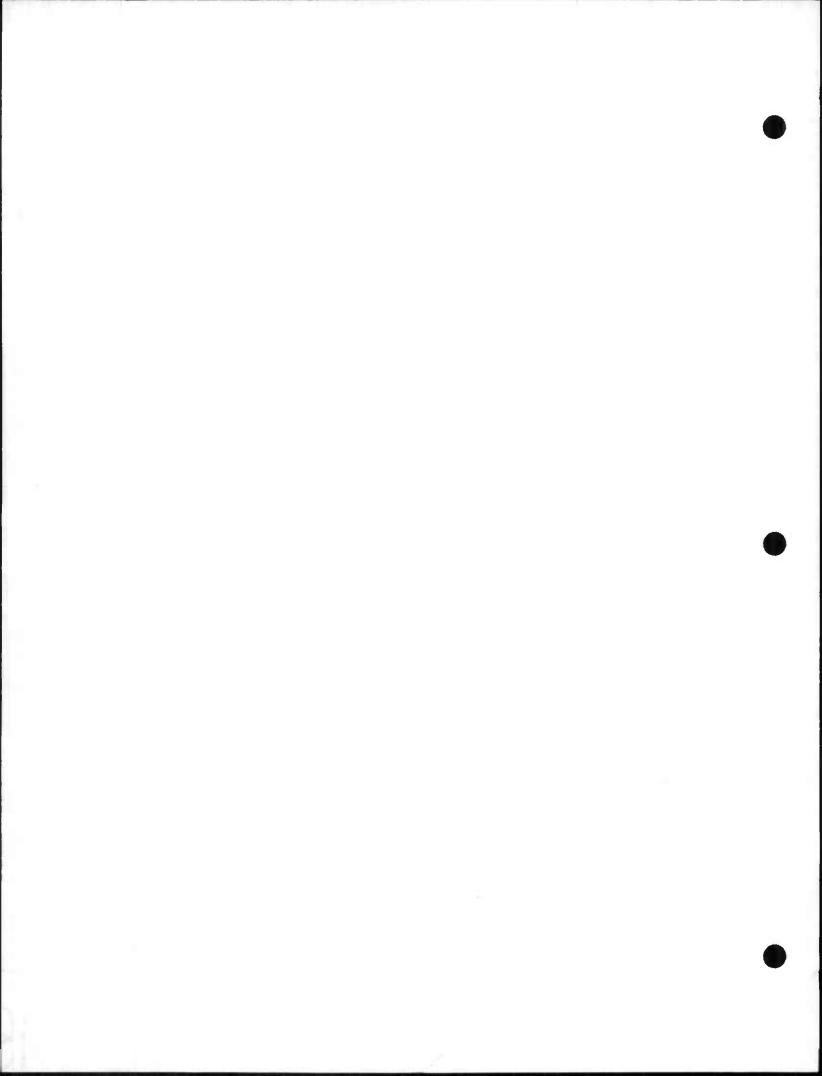


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4G PHYSICIAN: The law requires that the death certificate be executed within 24	ter this certificate has been signed by the attending physician and completely fill ath with the State Dept, of Health and Mental Hygiene prior to burial, cremation
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OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24	IAECTOR: After this certificate has been signed by the attending physician and completely fill vurs after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation
TAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24	RAL DIRECTOR: After this certificate has been signed by the attending physician and completely fill 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fill within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fill be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation

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	4. SOCIAL SECURITY NUME	BER	5. SEX		yrs. last birtho	ey) IF UNDER	1 YEAR	IF UNDE	R 24 HRS.	7. DA	TE OF BIRTH	-	8. BIRT	NPLACE (State or Foreign
	242-14-3288 ¹□M²\\$F		8	3 YR	MONTHS	DAYS	HOURS	MIN.		onth, Day, Year) 0/30/09		Nor	th Carolina	
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DIRECTOR	10645 Gre	en Mo	ountain	Cir	cle		Col	Lumb	ia				Howard	
	10a. STATE 10b. COUNTY					CITY, TOWN	OR LOCA	TION		_				10d. INSIDE CITY
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	1 Never Married 2	Married	FORCES?	YES	2 NO		if yes, sp	ecity Cubi	nn, Mexica	n, Puer	rto Rican, etc.)	or mo-	Blac	E — American Indian, ck, White, etc.
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exa	George E. MacNabb Cremation Society of Md., Inc. 299 Frederick Road Balto. MD 21228													
medicai examiner	23. PART I. Enter the diseases, Dr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest.  Approximate													
ent, the me	shock, or heart feliure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  a. Cavcinoma of the Colon with Metastas Is													
certification	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  Dehudration  DUE TO (OR AS A CONSEQUENCE OF):  Dehudration  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):													
hows any Inju	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PROPORT TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO													
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marked, BY PH		Pending Investigation		,/	1	М		YES 2 [	□ NO					
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3. REGISTRAR'S SIGNATURE



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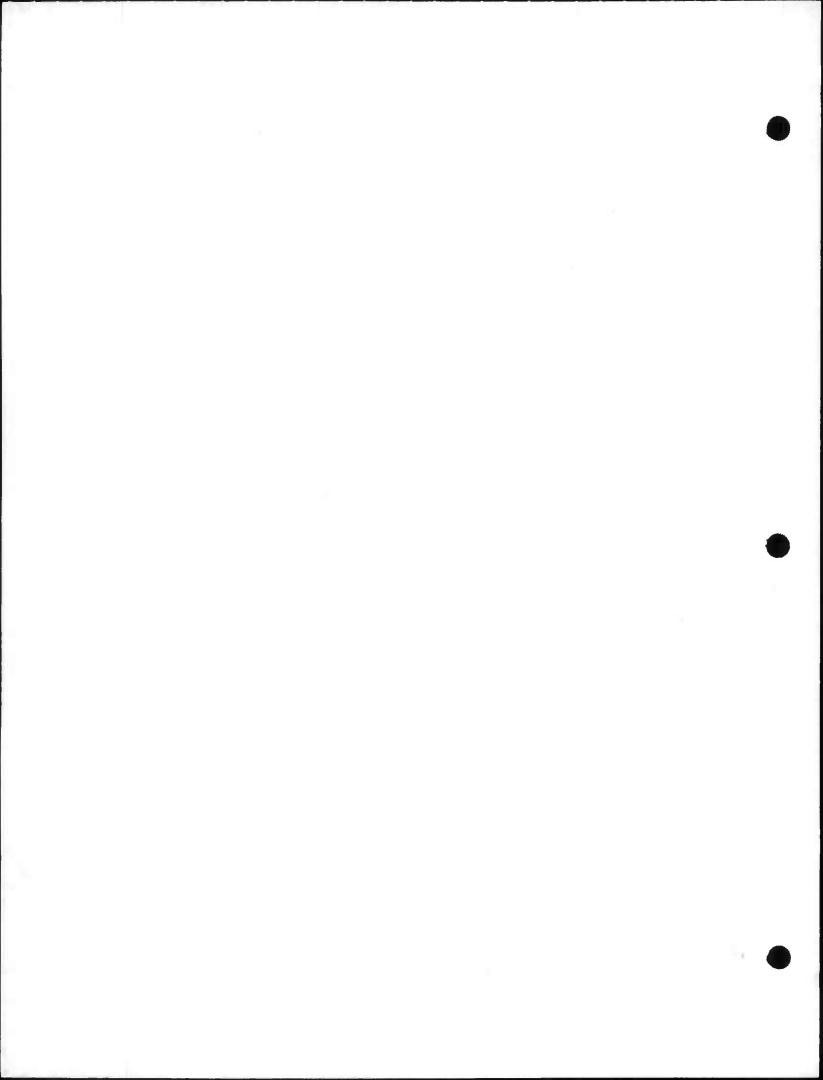
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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 ho	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the m
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH DAY 3. TIME OF DEATH YEAR Roche **Edward** Noland AM April 5 1993 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign HOURS 1 M 2 - F 212-07-1170 YRS. 74 Feb. 16. 919 Maryland 9a. FACILITY NAME (If not institution, give stree 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Stella Maris Hospice Baltimore Towson RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD **Baltimore** Cockeysville 1 - YES 2 1 NO 10e. STREET AND NUMBER FUNERAL 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21030 5 Hickory Hill Rd. USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 ANO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, Whits, etc. Il yes, specify Cuben, Maxican, Puarto Ri 1 — YES 2 A NO Specify: 1 Never Married 2 Marrie IF YES, GIVE WAR OR DATES BY Specify 3 Xidowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KINO OF BUSINESS/INDUSTRY (Specify only high lary (0-12) College (1-4 or 5+) Kitchen Construction 12 Cabinet Maker 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) William Roche BE Olga Hook 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Patricia Brennan 14 Hickory Meadow Rd., Cockeysville, MD 21030 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE 1 Surial 2 Cremina.
4 Donation 5 Other (Seccity) Dulaney Valley Mem. Gardens 4/7/93 Timonium, MD PL SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Lowell M. Lemmon On Lemmon-Mitchell-Wiedefeld, Inc. 10 W. Padonia Rd., Timonium, MD 21093 a diseas es, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, Approximate shock, or heart feilure. Liet only one ceuse on each line. interval Between **IMMEDIATE CAUSE (Finel** Onset and Death disesse or condition resulting in death) Netastatic DIDA DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in desth) LAST PART II. Other eignificent conditione contributing to deeth but not resulting in the underlying ceuse given in Part i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH? NO 1 | YES 2 | NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

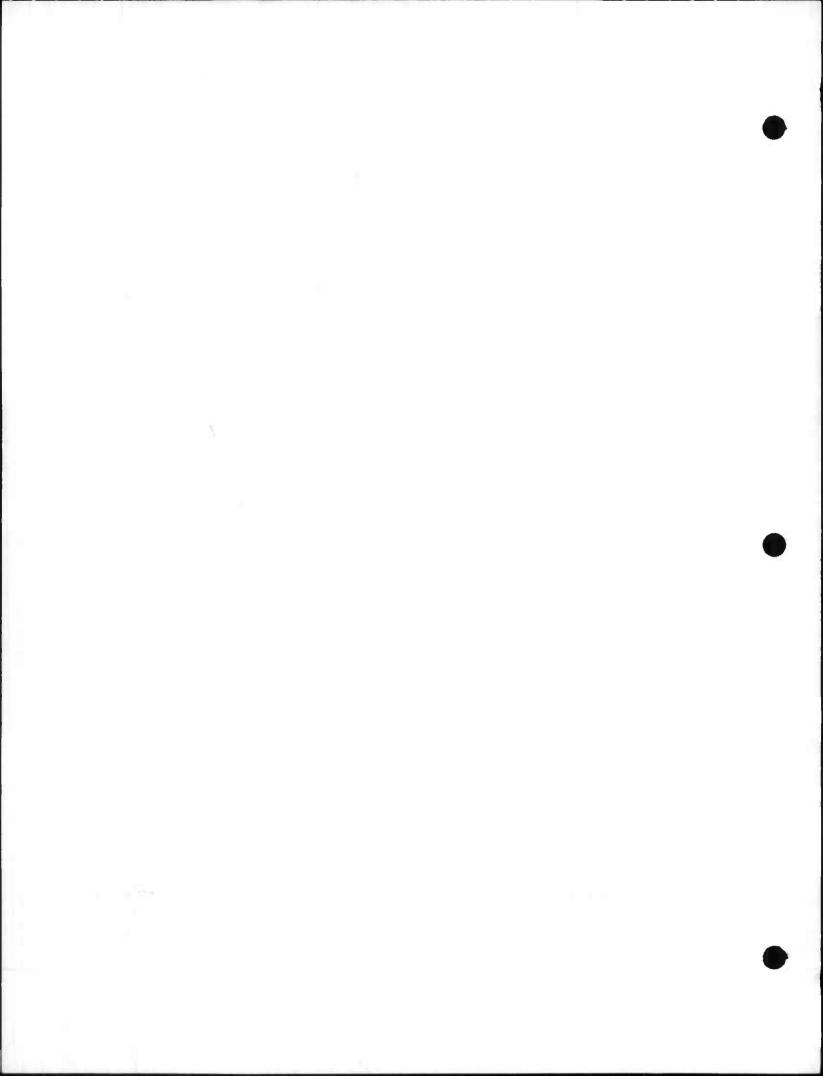
1 YES 2 NO 26. PLACE OF OEATH (Check only one) HOSPITAL: OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 8 Other (Specify) 27. MANNER OF CEATH 28s. OATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? AND OESCRIBE HOW INJURY OCCURED INJURY 1 Natural 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, larm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER ш 29d. DATE SIGNED (Month, Day, Year) 2 93 le 8 4-0 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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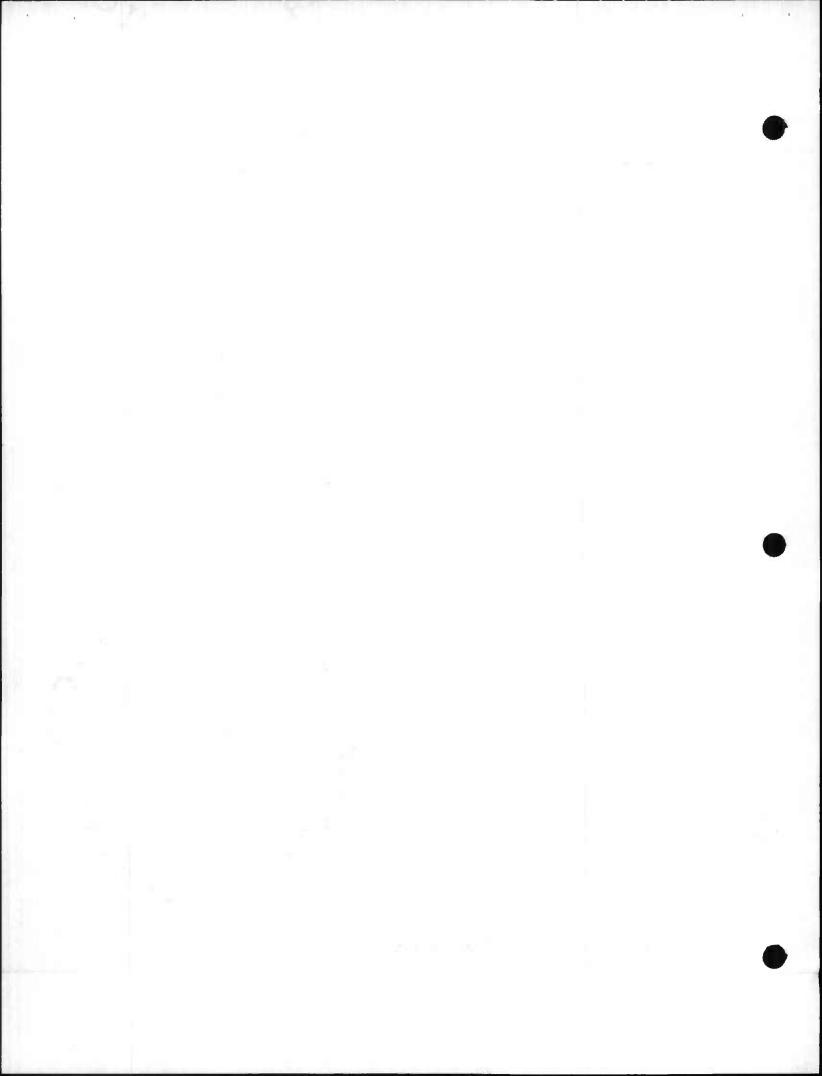
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		1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE	OF DEATH	v v.		IME OF DEATH
		Mary Smith					Apri		1993	AR	3:10 P
		4. SOCIAL SECURITY NUMBER 245 - 58 - 0802	1 🗆 M 2 💢 F		THE DAYS	IF UNDER 24 HRS. HOURS MIN.	(Month	OF BIRTH , Day, Year) 13-19		Country)	E (State or Foreign
3 should	(m)	Sa. FACILITY NAME (If not institution, give st		9b.		OR LOCATION OF D			9c. COUNTY	OF DEATH	
1, 2, 3	Ē	Maryland General Hospital Baltimore City									
permit. Pages 1	DIRECTOR	10a. STATE 10b. COUNTY			timo						INSIDE CITY LIMITS? YES 2 NO
EL ed	A L	10e. STREET AND NUMBER	101. ZIP CODE			H. ZIP CODE			10g. CITIZEN		
an. ransit	FUNERAL	4511 Manorden	e Rd. APT. A 212			21229				A	
215-0020 rattending physician. use as the burial-transit	BY FUI	11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. WAS DECEDENT EVER IN U. FORCES? 1 YES :	2 X NO	If yes, s	CENDENT OF HISPA pecify Cubert, Mexic S 2) NO Speci	an, Puerto R	? (Specify Yes licen, etc.)		RACE — A Black, Whi Specify: B	
215 attend	G	15. DECEDENT'S EDUC (Specify only highest grade		Sa. DECEDENT'S USU			16b.	KINO OF BUS	INESS/INDUST		
A S S	COMPLETE	Elementary/Secondary (0-12)	College (1-4 or 5+)  (Give kind of work done during most of working life. Do NOT use retired.)			ost of working					
AND the hospit detached	COM	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA					
4 A A A A A A A A A A A A A A A A A A A	E 111	Leroy Perry				Mary	Mont	gomer	У		
MAR retained 5 should	TO BE	19a. INFORMANT'S NAME (Type/Print)  Rosa Davis				and Number or Rural					10 0100
	8	200, METHOD OF DISPOSITION	- Internal			ol Ave					MD 2122
6 may	Must	1 D Burial 2 Cremation 3 Ramo		ACE AND DATE OF DI	olecol		DATE		ATION - City		
ALTIMORE, leath. Page 6 may be funeral director, page xaminer must be		21. SIGNAÇURE OF FUNERAL SERVICE LICE	Western State    Committee, crematory or other colored   Western Star Cem.				Baltimore, MD				
SAL r death. e funer at.	examine	· (area )	boad		WM C	. MARCH	F.H				ΓΗ AVE.
hours after d ed in by the or removal.		23. PART i. Enter the diseases, or cashock, or heart failure. L	emplications that caused the ist only one cause on each	ne death. Do not e	enter the me	ode of dying, suc	ch aa card	lac or respir	ratory arrest,	Ī	Approximata intervai Between
24 1 IDn.		iMMEDIATE CAUSE (Final disease or condition	Onset					Onset and Deat			
ted within completely ial, cremat	פאפווו, ו	resulting in death)	Severe Pneur								
executed within and completely burial, cremai		_									
X 6	ATION	Sequentially list conditions, if any, leading to immediate	Respiratory failure DUE TO (OR AS A CONSEQUENCE OF):								
ate be e		Cause Enter LINDERLYING	Cerebrovascular accident								
certific ding ph Hygiene	TF	that initiated eventa resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):								
O DE	CER	d d									
- 0 E	AL C	PART II. Other algorificant conditions	contributing to death but	not resulting in th	ne underlyin	g cause given in	Part i.	24a. WAS AN			E AUTOPSY FINDINGS
RECORD requires that the een signed by th of Health and N	MEDIC/					PERFORMED?		MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
OI	MEDIC									YES 2 NO	
S S S	N N										
	HYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)  HOSPITAL:  OTHER:								
OF VITA PHYSICIAN: The	1 XS	1 YES 2 NO 27. MANNER OF DEATH	26e. DATE OF INJURY	ent 3 DOA 4 D	Nursing Hon		once 6 Other (Specify)				
PHYSIC C	1	1 Natural 5 Pending	(Month, Day, Year)	28b. TIME OF INJURY	W	JURY AT ORK? YES 2 NO	28d. DEŞ	CRIBE HOW IN	JURY OCCUR	D	
	1 2	2 Accident Investigation 3 Suicide 6 Could not be	26s. PLACE OF INJURY —	At home, tarm, street			281, LOCA	TION (Street a	nd Number or F	tural Brusta I	Vermber
DI ATTENDING I DIRECTORING I DIRECTORING I	1	4 Homicide 6 Could not be	building, stc. (Specify)					or Town, State)	TO THOMBON OF THE	avair riodio r	runnau,
THE HOSPITAL DIR ATTENDING THE FUNERAL DIRECTOR IN filed within 72 hours PORTANT: If fem RE COMBI	티	29a. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.								
HOSPITAL FUNERAL within 72	COMPL		R: On the basis of exemination ar							use(a) and	manner as stated.
TO THE HOSPIT TO THE FUNERA De filed within 7		29b. SIGNATURE ARE TITLE OF CERTIFIER				29c. LICENSE MUMBER			29d. DATE SIGNED (Month, Day, Year)		
55 54 FE 59 54 54 54 54 54 54 54 54 54 54 54 54 54	8	EAstaha	MIND			N/A Lu.L		1.9	3		
F F B :	티입	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH	(ITEM 27) (Type, Print	t)	1					_
		M. Esfahani, M.	D. c/o Marv1	and Gener	al Ho	spital					
		M. Esfahani, M. 31. DATE FILED (Month, Dey, Year)  APR 09 1993	32. REGISTRAR'S SIGNATU	IRE		1					
		APR U 9 1993	gulia Davidson	- Aandelle							

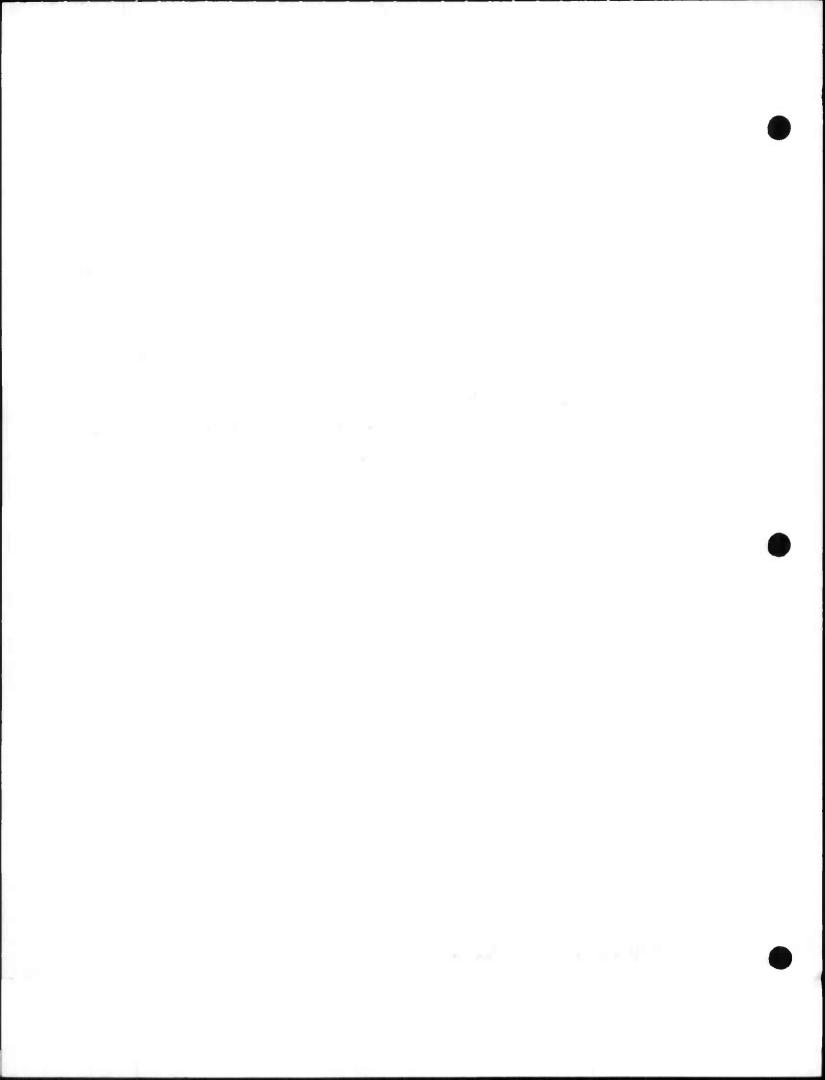


		1 - FOR STATE REGISTRAR	STATE OF MARYLA			HEALTH AND	MENTAL HYGIE REG. N		3 09985	
020 physician. burlat-transit permit. Pages 1, 2, 3 should		1. DECEDENT'S NAME (First Mirista 1,851)	Albert Cha	rles Sc	hlimme,	, Sr.	2. DATE OF DEATH MONTH	DAY G	3. TIME OF DEATH 3. TIME OF DEATH 3. TIME OF DEATH	
		4. SOCIAL SECURITY NUMBER 218-03-6103	/	yrs. lest birthday) 71 YRS.	IF UNDER 1 YEAR		7. DATE OF BIFITH (Moritb, Dav. Year)  1 - 22 - 192		BIRTHPLACE (State or Foreign Country) Maryland	
	FUNERAL DIRECTOR	De. FACILITY NAME (If not institution, give str Mercy Hospito			9b. CITY, TOW	n on Location of the Baltimore		9c. COUNTY	Y OF DEATH	
		RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY  Maryland	Baltimore	10c. CIT	Y, TOWN OR LO	Edger	nere		10d. INSIDE CITY LIMITS? 1  YES 2  NO	
		9108 AVENUE B				101. ZIP CODE	1219		n of what country? ited States	
215-0020 attending physician. se as the burial-tra	ВУ	11. MARITAL STATUS 1 Never Married 2 1 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN IT FORCES? XIX YES IF YES, GIVE WAR OR DAT AMMU WW T	2 NO	If yes.		UNIC ORIGIN? (Specify Year, Puerto Rican, etc.)	bs or No— 14	I. RACE — American Indian, Black, White, etc. Specify: White	
MARYLAND 21 retained by the hospital or 5 should be detached for u notified at once.	TO BE COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) 11th Grade			USUAL OCCUP, work done during se retired.) LNECT	ATION i most of working		CO & BO	Rail ackriver Road	
		17. FATHER'S NAME (First, Middle, Lest) Albert Charles S	Schlimme					First, Mickille, Meiclen Surneme) Porter		
		190. INFORMANT'S NAME (Type/Print) Lily M. Schlimme			AV enue		nere, Mary		21 21 9	
		20e. METHOD OF DISPOSITION 1	vel from State 20b. P	PLACE AND DATE	50Wice	corp.	4/72/93 T	owson,	y or Town, State Maryland	
0 = 0		21. SIGNATURE OF FUNERAL SERVICE LICE	Loh		7922	2 Wise Av	enue Dund	lalk, Mo	ndalk, Inc. aryland 21222	
RECORDS, P.O. BOX 68760, requires that the death certificate be executed within 24 hours aft tern signed by the attending physician and completely filled in by Laft Health and Mental Hygiene prior to burial, cremation, or remo shows any injury, or other traumatic event, the medica		21. PATE 1. Enter the diseases, prospective. Limited in the condition resulting in death)	Bacteria Due to (or as a co	mia.	F):	mode of dying, su	ch as cardiac or res	piretory arres	t, Approximata interval Between Onset and Death	
	N: MEDICAL CERTIFICATION	Sequentielly list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A CO	atic	Pros	tate Co	wanor	na.		
		PARTIL Other eignificent conditions Chronic Obs	tructive Pa	t not resulting	in the underly	ving cause given in	Part I. 24a. WAS A PERFC	ORMED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2 NO	
N. The Keep h	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 1 Propertient 2 ER/Output	lent 3 🗆 DOA	OTHER:	PLACE OF DEATH (C	743			
N OF V PHYSICIA IN WITH THE BARKED, OF	ВУ РН	27. MANNER OF DEATH  1: Maturel 5 Pending 2 Accident Investigation	28s. DATE OF INJURY (Month, Day, Year)	28b. TIM	URY	INJURY AT WORK?  YES 2 NO	28d. DESCRIBE HOW	INJURY OCCUP	RED	
TO ON THE OWNER OF S. after death n. 28 is man	ETED 8	3 Suicide S Could not be determined	28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, etc. (Specify)		office 261. LOCATION (Street and Number or Rural Route Numb City or Yown, State)		Rural Route Number,			
OSPINATE NOWS	COMPLE		IAN: To the best of my knowled On the basis of examination a						isuse(s) and manner as stated.	
TO THE HOSP TO THE FUNEH be filed within IMPORTANT?	TO BE	296, SIGNATURE AND TITLE OF CERTIFIER	NID			Arm ZSS		29d. DATE S	RIGNED (Month, Day, Year)	
		30. NAME AND ADDRESS OF PERSON WHO GO Mercy Medica	1 Conton S.	+ Pau	is pla	ace Ba	ltimore	mD		
		APR 09 1993	39. REGISTRAR'S SIGNAT	Mandelle.		,				



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	State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	23
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	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM	MENT OF HEALT	AND ME	NTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)					DATE OF DEATH		3. TIME OF DEATH		
	RONALD	L.	SPIN	NICCHIO,	Jr.	04 05	1993			
	4. SOCIAL SECURITY NUMBER		_	UNDER 1 YEAR IF UND	ER 24 HRS. 7.	DATE OF BIRTH	1 8	RTHPLACE (State or Foreign puntry)		
	216-56-1800		3 YRS.			OV. 5, 19	949 î	Maryland		
æ	9a. FACILITY NAME (If not institution, give s		98	. CITY, TOWN OR LOCA	TION OF DEATH	Н	9c. COUNTY O	F DEATH		
Ē	SINAI HOSPITAL	SINAI HOSPITAL BALTIMORE								
DIRECTOR	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY									
	Maryland Baltimore 1½ ves 2									
FUNERAL	100. STREET AND NUMBER 1024 Dartmouth Road 101. ZIP CODE 21212 109. CITIZEN OF WHAT COUNTRY? U.S.A.									
O.	11. MARITAL STATUS	12. WAS DECEDENT EVER IF	U.S. ARMED	13. WAS DECENDENT			or No — 14. R	ACE American Indian,		
BY F	12 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES		NO If yes, specify Cuben, Mexicen, Puerto Rican, 1 ☐ YES X NO Specify:			c.) Black, White, atc. Specify: White			
	16. DECEDENT'S EDU	CATION	16a. DECEDENT'S US	IAL COCUPATION						
ETE	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Give kind of work life. Do NOT use re	done during most of won	ting	16b. KIND OF BUS		<b>'</b>		
APL	12	College (I-V or 5 V)	Waiter			Rest	aurant			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			18, MO	THER'S NAME	(First, Middle, Maiden	Sumame)			
BE (		Spinnicchio,			Ann					
0	19a. INFORMANT'S NAME (Type/Print)		100	DRESS (Street and Numb						
	Colegate O. McSha		PLACE AND DATE OF D	Wingate Ro	ad, Ba					
	1 Buriet 2 Cremation 3 Rem			placed corp	4-9		CATION — City of	Charles and the Control of the Contr		
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	1	22. NAME AND ADDR						
	· Wallace.	S Brooks	Dr.	Ruck Tows 1050 York				204		
	23. PART i. Entar the diseases, or o	complications that caused	the death. Do not	antar tha mode of d	ying, auch as	a cardiac or reapi	ratory arrest,	Approximata		
	ahock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final Gleaner or condition)									
	immediate cause (Final disease or condition resulting in death)  a. Shotgun Wound of Face and Right Shoulden Onset and Death Oue TO (O)(AS A CONSEQUENCE OF):									
_	OUE TO (OF AS A CONSEQUENCE OF):									
ō	Sequentially list conditions, if any, leading to immediate  DUE TO (OR AS A CONSEQUENCE OF):									
S	cause, Entar UNDERLYING	cause, Enter UNDERLYING CAUSE (Disease or injury								
	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):							
CERTIFICATION	rosaning in death) Exist	d								
AL (	PART II. Other significant condition	a contributing to death b	ut not resulting in ti	ha underlying cause	given in Par			24b. WERE AUTOPSY FINDINGS		
MEDIC						PERFOR		AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?		
ME						_		1   YES 2   NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL									
Sic	EXAMINER?	HOSPITAL:		26. PLACE OF THER:						
H	27. MANNER OF DEATH	1 Inpatient 2 ER/Outp	26b, TIME OF	Nursing Home 5 F		Other (Specify)	LIURY OCCUREO			
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) INJURY WORK?								
	3 Suicide 6 Could not be	26s. PLACE OF INJURY — At home, farm, street, factory, office building. stc. (Specify)					NASINGEL AND WINDOW OF BURN POULS NUMBER WD SHORT I MOUTH ROAD			
ETE	AT HOME BALTIMORE, MARYLAND 2121									
COMPLETED		CIAN: To the best of my knowl			e, end due to ti	the cause(s) and man	ner as stated,			
Ö	one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.									
BE	296. SIGNATURE AND TITLE OF CERTIFIER	,	29c. LIC	ENSE NUMBER	R	29d. DATE SIGN	SIGNED (Month, Day, Year)			
20. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							04/	05/1993		
	SU. NAME AND ADDRESS OF PERSON WHO									
	31. DATE FILEO (Month, Day, Year)	LANTE MD	III Penn	Street.	Balt	imore.	Maryla	ind 21201		
	APR - 9 1993	Julia Davidour	-Andelle							



director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. I	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral be filed within 72 hours after death with the State Dept. of Health and Mental Myglene prior to burial, cremation, or removal.	
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	within	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the furbe filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	
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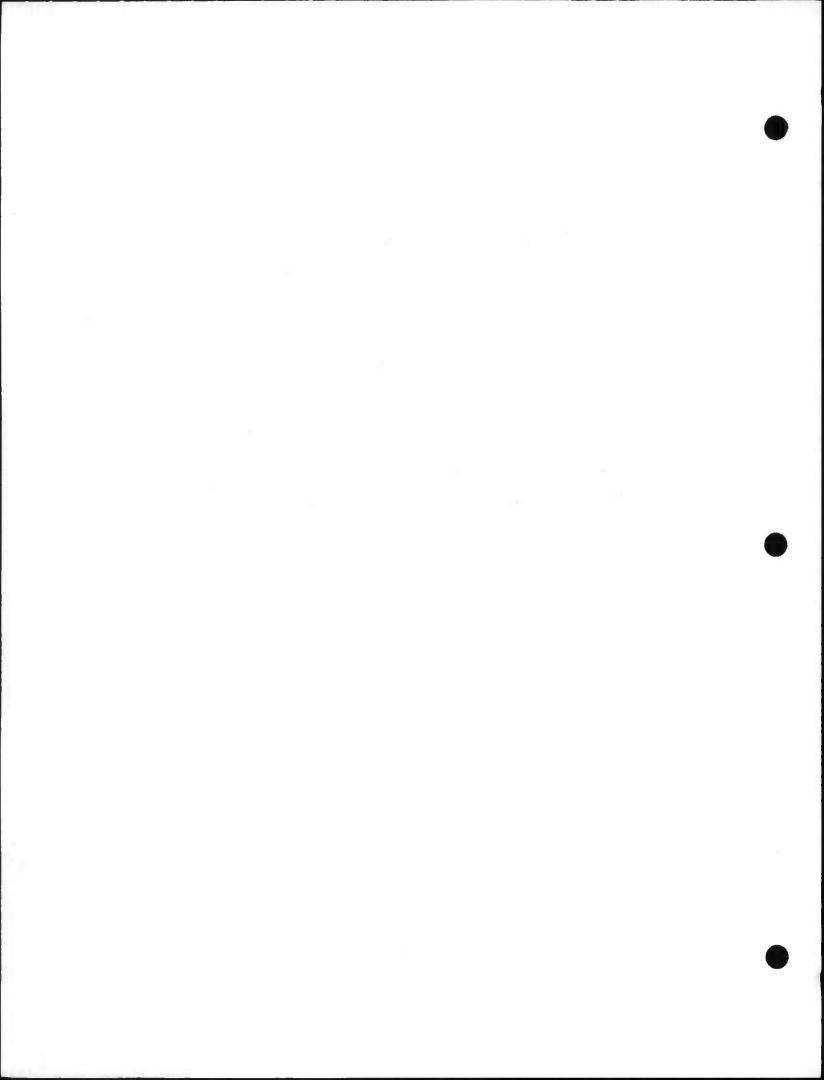
	FOR		STATE OF I	MARVI	AND /	DEPAR	TMENT	UE H	EAITU	AND I	MENTA	UVCIEN	E (	93	09987
	1 - STATE REGISTRAR		OIMIE OI I	WATE	CE	RTIF	CATE	OF	DEA	TH	MENIA	REG. NO.			
	1. DECEDENT'S HAME (First,	Middle, Last)									MONT	OF DEATH	NA.	YEAR	3. TIME OF DEATH
	EDWAR	DASC									4	6		93°	12.17 h
	216-14-389		5. SEX 1		in yrs. lesi		IF UNDER MONTHS	DAYS	HOURS	24 HRS.	(Monti	OF BIRTH 1, Day, Year) 7⇔03⇔1.	922	8. BIRTH Countr	IPLACE (State or Foreign y) USA
	9a. FACILITY NAME (If not ins	stitution, give si	reet and number)				9b. CITY,	TOWN C	R LOCATI	ON OF DE				HTY OF D	
CTOR	ER FALLSTON	GENERA	L HOSPI	CAL				1.		***	FA	LLSTON			HARFORD
REC	10a. STATE	10b. COUNTY	-			10c. CITY	r, TOWN O	R LOCAT	ION						10d. INSIDE CITY
ä	MD	HAI	RFORD			EI	GEWO	OOD							LIMITS?  1 YES 2 XNO
ERAL	10e. STREET AND NUMBER							100	. ZIP COD	E			10g. CIT	IZEN OF V	WHAT COUNTRY?
H	612 DOGWO	OD AVI	ENUE						21	040				USA	A
FUN	11. MARITAL STATUS	Married	12. WAS DECEDEN FORCES? 1	T EVER I	U.S. AR	MED						l? (Specify Yes Rican, etc.)	or No-		E — American Indian, k, White, etc.
84	3 Widowed 4 Divor		FORCES? 1	WIT OR D	ATES					Specify		,		Speci	
0	15. DECE	EDENT'S EDUC	CATION	~ 77	16a, DE	CEDENT'S	USUAL OC	CCUPATIO	ON		16b	KIND OF BUS	UNESS/IN		HITE
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교	12			,	POI	ICE	OFFI	CER			BZ	TATO.	CITY	POLI	CE DEPT.
examiner must be notified at once.  TO BE COMPL	17. FATHER'S HAME (First, Min	ddle, Last)									ME (First, I	Middle, Maiden	Surname)		
BE at	EDWARD G. S											ZAPF			
2	19a. INFORMANT'S HAME (Ty											ber, City or Town			
90	ELOISE SCHM									EDGE	-	, MD.			
	20e. METHOD OF DISPOSITION  1 Burial 2 Cremation	n 3 Reme	oval from State			HEA				CHEN	DAT			City or To	
	41 Donation 5 Other		EHSEE	_ SA	CREL	) HEA				SS OF FA	4-1	U BAI.	LITI	RE M	1).
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event, the medical	23. PART I. Enter the dishock, or he iMMEDIATE CAUSE (Findisesse or condition resulting in death)	eert fellure. I	ACUTE C	CORON	ach ilne.	•	RY D			ing, suci	n as card	llec or respi	ratory ar	reat,	Approximata Interval Between Onset and Death
CERTIFICATION	Sequentially list condition if any, leading to immed cause. Enter UNDERLY!! CAUSE (Disease or injust that initiated events resulting in death) LAST	ons, diate NG ry	à			DUENCE OF									
MEDICAL	PART II. Other significan	H C	S/P CARO	ION					cause (	given in	Part I.	24a. WAS AH PERFOR 1 YES 2	MED?	24b	WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  YES 2 NO
IAN:	25. WAS CASE REFERRED TO			T. T. U	ENDA	VIEK	rew I.O.		ACE OF D	EATH (Ch	eck only on	e)	-		
SICI/	1 YES 2 NO		HOSPITAL: 1 Inpatient 2	XER/Outp	etlent 3	□ DOA	OTHER	<b>1</b> :			6 🗆 Othe				
미수	27. MAHHER OF DEATH		26a. DATE OF (Month, D	IHJURY		28b. TIME	E OF	28c. INJ				CRIBE HOW II	NJURY OC	CURED	
BY PF		Pending nvestigation	N.			N.		1 🗆 1		] NO		N	IA		
2 0		Could not be	28e. PLACE O building,	otc. (Spec	·— At hor	me, farm, s	treet, facto	ory, office				ATION (Street a or Town, State)	ind Numbe	r or Rural F	Route Number,
ط ا ۲						N	<u>A</u>						NA		
O BE COMPLE	The second secon		CIAH: To the best of e												i) end menner es stated.
E C	296. SIGNATURE AND TITLE	OF CERTIFIER							29c. LIC	ENSE NUM	/BER		29d, DAT	E SIGNED	(Month, Day, Year)
8 8	4 miss	1/2	-M	DM	E				43. 1110	1809				4=6=	
2	30. HAME AND ADDRESS OF	PERSON WH	COMPLETED CAU			4 27) (Type,	Print)		ע ב	1003				4=0=	T 3 2 3
	G.S. PRABHU N 1912 DATE FILED (MONTH, Day, 1 APR 09 1993	Mane)	810 BELA Davidson	IR R	D #	102	FALL	STON	MD.	210	47	tn 410	<u>879</u>	<u>≈656</u>	4.

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	rector,	The bound with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	If them to be marked on Norm 20 about one follows on abbee bearingful about the market bearing the second to the s
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HOSPINIAGE	FUNEFAL	within About	TANT: If Item
TO THE	10 1	be filled	MPOR

	FOR 1 - STATE		STATE OF I	MARYLA	ND / DEF	ARTMEN	T OF I	HEALTH	AND	MENTA		E	J	0 9 9 0 0
	REGISTRAR  1. DECEDENT'S NAME (First	Mirirlin Last)			CEHI	IFICAT	E Ur	DEA	TH	I - DATE	REG. NO.			
	Charles		pert TRA	ACEY						MONT	TH DA		YEAR	3. TIME OF DEATN
	4. SOCIAL SECURITY NUMBER		5. SEX	/	yrs. last birtho	my) IF I INTO	ER 1 YEAR	IE IMPE	R 24 HRS.	7 DATE	OF BIRTH		93	PLACE (State or Foreign
	216-01-3890		1 € M 2 □ F	83	YR	MONTHUE		HOURS		(Mont	th, Day, Year)	10	Countr	γ)
1 3	9s. FACILITY NAME (If not in						V TOWN	OR LOCATI	ION OF D		04 19			ryland
œ	St. Agnes H					100	Ltimo		ION OF DI	EAIN		9c. COU	NTY OF D	EATN
DIRECTOR	RESIDENCE OF DEC		31			Dal	LETIMO	ore_						
H N	10a. STATE	10b. COUNTY	γ		10c.	CITY, TOWN	OR LOCA	TION						10d. INSIDE CITY
ā	Maryland	Balt	imore				Ва	altin	nore				. 1	LIMITS?
AL	10e. STREET AND NUMBER						10	. ZIP COO	E			10g. CIT	ZEN OF W	VHAT COUNTRY?
1 1 1	2902 New Yo	rk Ave	nue					2122	27			U	.S.A	
FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1	T EVER IN	J.S. ARMED	13					N? (Specify Yes	or No-	14. RACE	- American Indian,
BY F	1 Never Married 2 3 X Widowed 4 Divo		IF YES, GIVE Y			İ		2 NO			Rican, etc.)		Specif	White, etc.
			l											" White
E	(Specify only	EDENT'S EDU	CATION completed)	1	(Give kind	T'S USUAL ( of work done IT use retired.)	during me	ON ost of world	ing	168	. KIND OF BUS	SINESS/INC	USTRY	
٦	Elementary/Secondary (0 7 th	l-12)	College (1-4 or 5		Truck					7,7	T Cowa	n Tr	ucki	na Co
COMPLETED	17. FATNER'S NAME (First, M	lidella ( mat)			TTUCK	DITAG	:1						ucki	ng co.
	Joseph Forr		RACEY								Middle, Maiden BOSI			
BE	19a. INFORMANT'S NAME (1		MAGEI		1 000 0000	WO 40005								
2	Constance A		AV								nore, N			
	20s. METHOD OF DISPOSIT		СУ		LACE AND DA			-	, Dc					
	1 XBurial 2 Crematic	n 3 🗆 Rem	oval from State	cemete	ery, crematory	or other place	1			1		CATION —		wn, State
1	21. SIGNATURE OF FUNERIA		ENSEE //	771	ne Gr			ND ADDRE			0 Park	ton,	MD	
1 1	No.	110	41	No	11						HOME, 1	NC.		
$\vdash$	· Ju	200	~	1	N						Balti			21229
	23. PART I. Enter tha di shock, or h	iseases, or c eart fallura.	complications the List only one cau	it caused t	ha daath. C h lina.	o not ante	r tha mo	da of dy	ing, suc	h as can	diac or respi	ratory sn	rest,	Approximate Interval Between
	IMMEDIATE CAUSE (FIR	nai												Onset and Death
	disesse or condition reaulting in death)	<b>→</b>	e. COL	relio	pole	mono	my	00	vesi	+				
No.	Sequentially liet conditi	lone,	b	were	ONSEQUENC	20 80	edu	re						
F	If any, leading to imme- cause. Enter UNDERLY!	diate	Due 10	O O O	ONSECUENC	E OF):								
윤	CAUSE (Disease or Inju		c. DUE TO	(OR AS A C	ONSEQUENC	F OFI-								
ERTIFICATION	resulting in death) LAS	T	5-1-10	(01170710	01102002110	. 01 ).								i
핑			d											-
A	PART II. Other algnifics	nt condition	a contributing to	death but	not reaulti	ng In tha u	nderiyin	g cause	given in	Part I.	24a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDICA											1 TES 2			COMPLETION OF CAUSE OF DEATH?
¥						_								1 TES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:					ACE OF D	EATH (Ch	eck only or	ne)			
ls.	1 TES 2 NO		1 Inpatient 2	ER/Outpati	lent 3 🗆 DO	OTHE		10 5 🗆 Ri	ealdence	8 🗆 Othe	r (Specify)			
王	27. MANNER OF DEATH		28e. DATE OF (Month, D		28b.	TIME OF	28c. INJ	URY AT		28d. DE	SCRIBE HOW II	JURY OC	CURED	
ВУ		Pending Investigation		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		М		YES 2	□ NO					
	3 Suicide 8	Could not be	28e. PLACE O	F INJURY -	At home, far	m, street, fac	ctory, offic			281. LOC	ATION (Street a	nd Number	or Rural R	loute Number,
	4 Homicide	determined								0.17	or lowing chancy			
COMPLETED	29a. CERTIFIER (Check only 1 CERT	IFYING PNYSI	CIAN: To the best of	my knowled	ige, death occ	urred at the	lime, deta	and place	, and due	to the car	use(a) and men	ner se stet	ed.	
No.														) and manner as stated.
	296, SIGNATURE AND TITLE	OF CERTIFIER	1					29c. LIC	ENSE NUM	MBER		29d, DAT	E SIGNED	(Month, Day, Year)
BE C			100	N	C-Cl	10			P64		ciden			
2	30. NAME AND ADDRESS OF	PERSON WH	O COMPLETED CAUS	SE OF DEATH	H (ITEM 27) (	ýpe, Print)								
	De C-CHO,	DEP	7 OF 1	neDi	LINE	2 ST	· AG	NEC	H	bspi	TAL			
	31. DATE FILED (Month, Day,	Ybar)	32 REGISTRA	R'S SIGNAT	URE			3						
	15R 09	1993	Guil.	The state of the s	gande	-								



		FOR
1	_	STATE
•		REGISTRAR

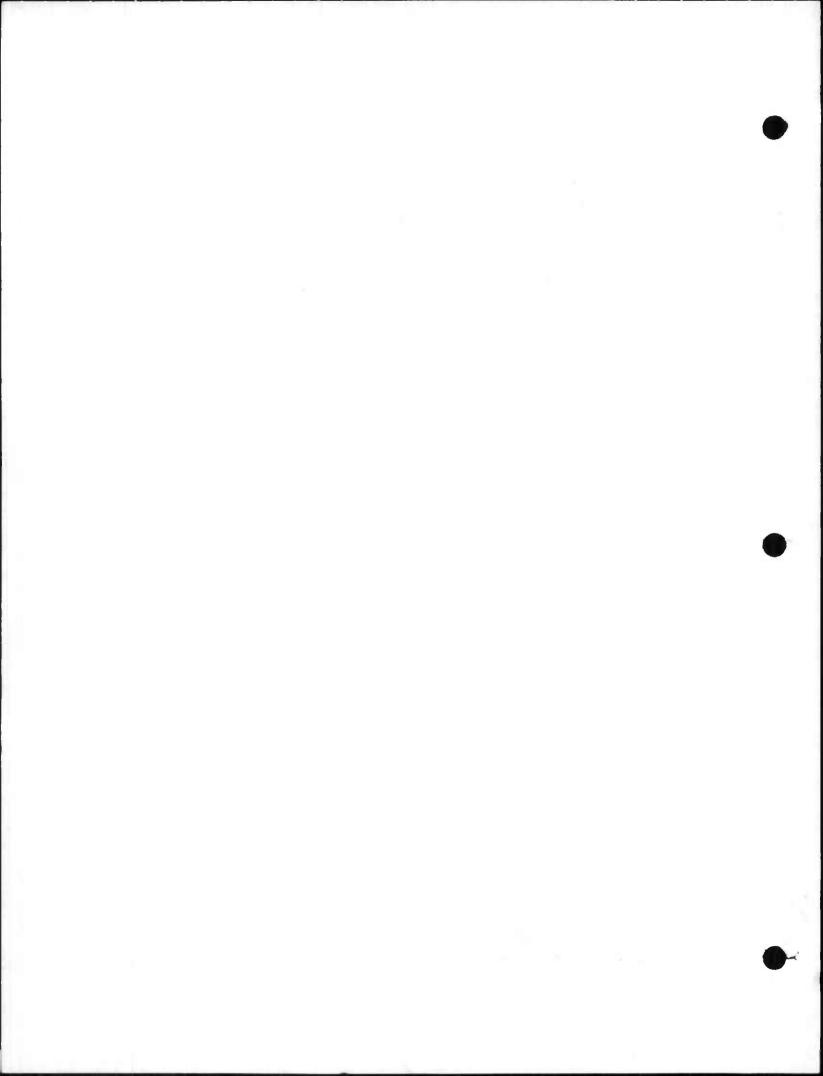
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HADDEN

. 1		1 - STATE REGISTRAR  1. DECEDENT'S NAME (First, Middle, Last)	SIXIE OF M			ICATE	OF	DEATH		REG. NO		1,	TIME OF DEATH
	- 1	William Bru	ce Wilev						MONTI 4	1 0	ay y 9:	EAR	
		4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. le	ast birthday)	IF UNDER 1	YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH			12:40 A/M
i	- 1	223-30-2510	12(3X M 2 □ F	66	YRS.	MONTHS	DAYS	HOURS MIN.		n, Day, Year)		Country)	
3 should	- 8	9a. FACILITY NAME (If not institution, give at	reet and number)	66		9b, CITY, T	OWN O	R LOCATION OF DE		21/26	9c. COUNTY	Oh:	
60 gg	E I	D-11-i C			,								,,
	5	Baltimore County	General	Hospit	aL	Ra	nda	llstown			Ba.	lto.	
	DIRECTOR	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN OR	LOCATI	ION				10	d. INSIDE CITY LIMITS?
			Balto.		D	undal	k					1	YES 2 NO
8	3AL	10e. STREET AND NUMBER					10f.	ZIP CODE			10g. CITIZEI	OF WHA	T COUNTRY?
physician. burial-transit	FUNER	238 Pinewood R	oad				<u> </u>	2122	22		U.S.	.A.	
physician. burial-tran		11. MARITAL STATUS  1 X Never Married 2 Married	12. WAS DECEDENT FORCES? 1X			13. W	S DECE	ENDENT OF HISPAN	NC ORIGIN	? (Specify Ye	s or No- 14	. RACE	American Indian, hite, etc.
	ВУ	3 Widowed 4 Divorced	IF YES, GIVE WA		_	1 (	YES	2 NO Specifi	y:			Specify:	
as as	ED	15. DECEDENT'S EDUC	ATION	WWl		USUAL OCC	4104710						White
. 5	ETE	(Specify only highest grade	completed)		'Give kind of a	work done du	ring mos	st of working	166	. KIND OF BU	SINESS/INDUS	THY	
- 2 F	2	Elementary/Secondary (0-12)	College (1-4 or 5+)			,							
the hospit detached once.	COMPL	17. FATHER'S NAME (First, Middle, Last)			- '1	ester		18. MOTHER'S NA			ehem Si	teel	Corp.
at of the	Ü	Russell R. Wilev									Surriemej		
	0	19e. INFORMANT'S NAME (Type/Print)			ON MAILING	Anneses /	Charact are	Pansy			or Otalia Tira Ca	4-1	
5 5	2	Betty Delottinvi	116					le Ct.		1207	m, State, Zip Co	(90)	
may be		20a. METHOD OF DISPOSITION		20h PLACE		OF DISPOSITI	do do		DAT		CATION CITY	or Town	Ptoto
ator.		1€ Seurial 2 ☐ Cremation 3 ☐ Remo	wel from State			ther place) 1 Mem			4/8				, Maryland
		21. SIGNATURE OF PUNERAL/SERVICE LIC	ENSÉE //	111011	уптт			D ADDRESS OF FA		¥ 33	Dalti	liore	, Maryrand
death. Pag tuneral di L examiner		16/16/M	¥.	01						l Hom	e of	Dund	alk, Inc.
		( Nort "	12	1		79	22	Wise Ave	e. Du	ındalk	, Md.	212	22
within 24 hours spletely filled in t cremation, or re- rent, the med		23. PART I. Enter the diseases, prosphock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	Let only one caus	of AS A CONSI	18. ≥2 ~	Qu	G.	ce S	L S	nac or resp	iratory arrest		Approximate interval Between Onset and Death
and o bur	CATION	Sequentially list conditions, if any, leading to immediate	DUE TO (C	OR AS A CONSE	EOUENCE O	Pi:	nd	Mor	مما	my	5		
Phy Deby	RTIFICA	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (C	OR AS A CONSE	EQUENCE O	F):							
를 를 들	E	resulting in death) LAST											
the death y the attend Mental Injury,	Ö	PART II. Other significant conditions	contribution to d	laath hut nat	annulal no	le after cond			n I				
= 0 =	ICAL	Blinger		reen but not	resulting	in the una	ariying	cause given in	Part I.	24a. WAS AN PERFOI		AM	RE AUTOPSY FINDINGS AILABLE PRIOR TO
es that igned by ealth an		TI SULATIVE	3)						- 1	1 TYES 2	NO D		MPLETION OF CAUSE DEATH?
w requires been signe or, of Healti 3 shows a	ME	mypenen							— i			1 (	YES 2 NO
2 Se a	A	25. WAS CASE REFERRED TO MEDICAL										<u> </u>	
£ 9 9 5	SICIAN:	EXAMINER?	HOSPITAL:			OTHER:		ACE OF DEATH (Ch		,			
SICIAN: The certificate of the State	>- II	1 YES 2 NO	1 Inpetient 2 I		28b. TIM		g Home Sc. INJU	5 Residence					
DING PHYS After this death with	ВУ РН	1 Pending   S Pending   Investigation	(Month, Day		INJ	URY	WOF		28d. DES	CHIBE HOW	NJURY OCCUP	IEO	
TTENDI TTOR: A after da	E	3 Suickle 8 Could not be determined	26s. PLACE DF building, at	INJURY — At h	iome, tarm, i	street, factory	y, office		28t. LOC	ATION (Street or Town, State)	and Number or	Rural Routi	Number,
4 7 5 E	COMPLET	29a. CERTIFIER (Check only one)  1 CERTIFYING PHYSIC DESCRIPTION OF PHYSIC DESCRIPTION O	CAN: To the best of m									auso(a) an	d manner as stated,
TO THE HOSPIT TO THE FUNER De filed within 7	BE	296. SIGNATURE AND TITLE OF CERTIFIER	~					29c. LICENSE NUM	ABER		29d. DATE S	IGNED (MC	orith, Day, Year)
	5	30. NAME AND ADDRESS OF PERSON WHO							<u>,                                    </u>				
		Robert Kroopni 31. DATE FILED (Month, Day, Year)	32. REGISTRAR		Libe	rty R	d.	Balto	o. Md	. 212	01		
		APR - 9 1993	Julia De	widow-A	Boydan	<b>-</b> )							
			0										DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020





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0.000	attending physician	ntal Hygiene prior to
the state of the s	e attending physician and completely filled in by the funeral director, page 5 should be detached for use as the	fental Hygiene prior to burial, cremation, or removal.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hoss TO THE FUNERAL DIRECTIOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

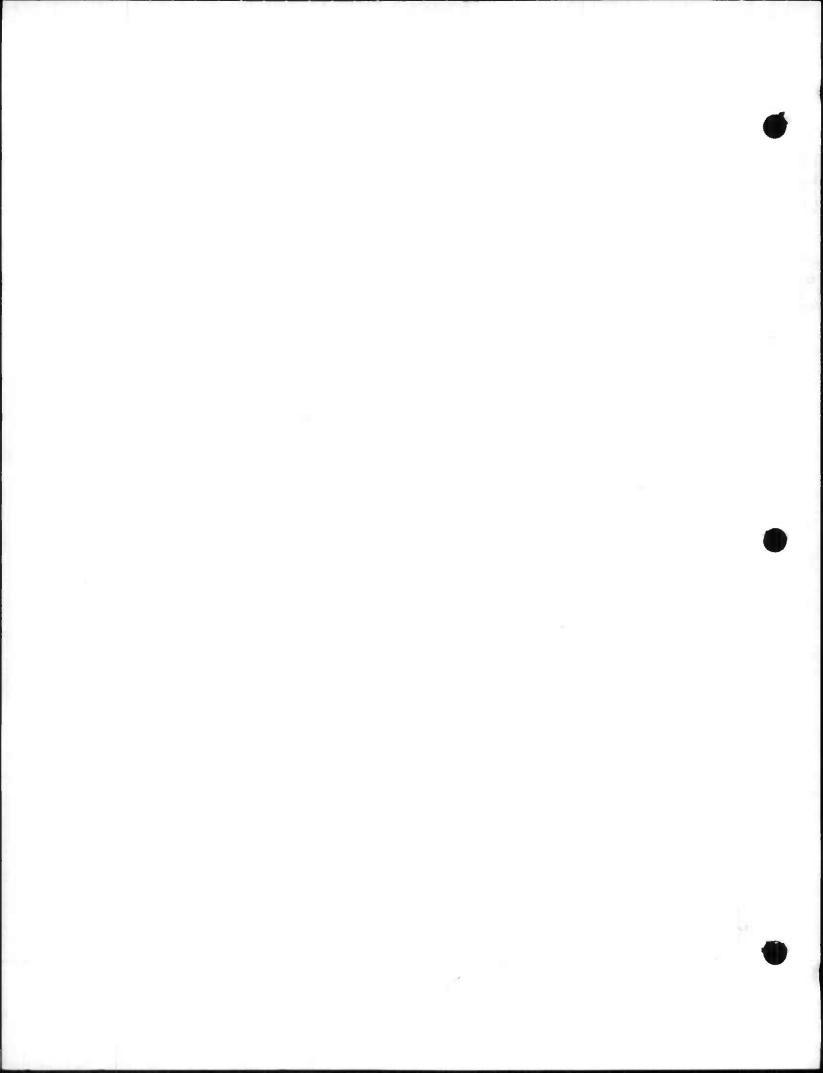
BALTIMORE, MARYLAND 21215-002

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	ICATE OF	DEATH	REG. N	O.	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	Raw .	3. TIME OF DEATH
- 0	PAUL WUNDER					4/6	BAY 93	2:40 AM
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIFTH		BIRTHPLACE (State or Foreign Country)
3	213-01-3527	1 KM 2 F	87 YRS.	MONTHS DAYS	HOURS MIN.	July 21	1905	Maryland
	9a. FACILITY NAME (If not institution, give s			9b. CITY, TOWN	OR LOCATION OF D	EATH	Bc. COUNTY	Y OF DEATH
OR	CHURCH HOSPITA	L CORPOR	ATION	BALTI	MORE CI	TY		
5	RESIDENCE OF DECEDENT  100. STATE 10b. COUNTY							
DIRECTOR	Md.	Baltimor	e 10c. CIT	Y, TOWN OR LOCA Es	TION Sex			10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER							1 YES 2 X NO
RA				10	1. ZIP CODE		10g. CITIZEI	N OF WHAT COUNTRY?
FUNERAL	629 Rockaway E				212			USA
5	11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEDENT E FORCES? 1	YES 2 NO	13. WAS DE	CENDENT OF HISPAI pecify Cuban, Mexica	NIC ORIGIN? (Specify Y	es or No- 14	. RACE — American Indian, Black, White, etc.
B	3 Widowed 4 Divorced	IF YES, GIVE WAR	OR DATES		2 XNO Specifi			Specify White
	15. DECEDENT'S EDU	CATION	16a. DECEDENT'S	I COCHECE	^**			
E I	(Specify only highest grade	completed)		vork done during m		166, KIND OF B	USINESS/INDUS	STRY
7	Elementary/Secondary (0-12)	College (1-4 or 5+)	Bake					
COMPLETED	5th  17. FATHER'S NAME (First, Middle, Lest)				I			
					18. MOTHER'S NA	ME (First, Middle, Maide	n Sumame)	
H	George Wunde	er	T 405 MAH DIO	1000000 101				
임	Frederick Wur	nder	629	Rockawa	y Beach	Ave. Balt:	un, State, Zip Co LMOYE M	id. 21221
	20a. METHOD OF DISPOSITION		20b. PLACE AND DATE	P DISPOSITION (III	-			
	20a METHOD OF DISPOSITION 1 D Burial 2 Cremation 3 Remote Proceedings of the Procedure of the Proced	oval from State	coGardenso	of plaPaith	4/9	/93 RO	ssvill	y or Town, State .e Md.
	21. SHOWATURE OF FUNERAL SERVICE LIC	ENSEE	1	22. NAME A	ND ADDRESS OF FA	CILITY		
	11 00 0	-	1 11			alHome 300	MaceAv	re. 21221
	1 mully	unila	& Hom	u				
	23. PART I. Enter the diseases, or o shock, or heart failure.	omplications that c List only one ceuse	sused the death. Do ron eech line.	ot enter the me	ode of dying, suc	h as cardiac or res	piratory arrest	t, Approximate Interval Between
	IMMEDIATE CAUSE (Final	1.254						Onset and Death
	disease or condition resulting in death)	1/1/2	TASTA	TIC	CA	660,	V	VIEARS
		DUE TO (OF	AS A CONSEQUENCE OF	7):				
Z	Sequentially list conditions,	À						
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (DE	AS A CONSEQUENCE OF	7):				
3	CAUSE (Disease or Injury	DUE TO 100	AS A CONSEQUENCE OF					
Ē	that initiated events resulting in death) LAST	JOE 10 (OF	AS A CONSEQUENCE OF	·);				i
岗								
	PART II. Other aignificant condition				g cause given in	Part I. 24s. WAS A		24b. WERE AUTOPSY FINDINGS
DICAL	- LAR	1N63	CTOMY			PERFO	RMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE
ш							2 (A) NO	OF DEATH?
2						_		1 TES 2 NO
₹	25. WAS CASE REFERRED TO MEDICAL			26. P	LACE OF DEATH (Ch	eck only one)		
PHYSICIAN: M	EXAMINER?  1 YES 2 NO	HOSPITAL:	R/Outpatient 3 DOA	OTHER:	ne 5   Residence	6 Other (Specify)		
¥	27. MANNER OF DEATH	28a. DATE OF IN.	IURY 28b. TIM	E OF 28c, IN.	JURY AT	28d. DESCRIBE HOW	INJURY OCCUR	RED
	1 Natural 5 Pending	(Month, Day,	Year) INJ		YES 2 NO			
BÁ	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF II	IJURY — At home, farm, s			261. LOCATION (Street	and Number or	Rural Bruin Number
	4 Homicide determined	building, etc.	. (Specify)			City or Town, State	)	
	29a. CERTIFIER 1 FF CERTIFYING PHYSIC	NAN: To the best of an	Marine Marine San Company	9 JH 1080 149	-200			
COMPL	(Check only one)  1 CERTIFYING PHYSIC ONE)							ause(s) and manner as stated.
ဗ ူ	29b. SIGNATURE AND TITLE OF CERTIFIER			n, in my opinion, i				
	1 1 1				29c. LICENSE NUM		29d. DATE S	IGNED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO	rem	NO		D173	12	7/	0/93
- 1				Edmind I				
	ATAOT.T.AH IF NIA	COMPLETED CAUSE (	OF DEATH (ITEM 27) (Type,	TO TO TO TO				21231
	ATAOLLAH F. NAZ	ZEMI, M.I	O. 100 N.	BROAD	WAY STR	EET, BAL	TIMOR	21231 E MD @***
	ATAOLLAH F. NAZ  31. DATE FILED (Month, Day, Year)	ZEMI, M.I	O. 100 N.	BROAD	WAY STR	EET, BAL	TIMOR	21231 E MD <b>@*@</b> **

DHMH-16 Rev 1/89



BALLIMORE, MARYLANI	TO THE MENTING OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 frouts after death. Page 6 may be retained by the hos	TO THE FLACEOIL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 5 should be detached an information or removal.	IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
Jon, BALI	led within 24 hours after death.	completely field in by the funeral	event, the medical examin
THE PROPERTY OF VITAL RECORDS, P.O. BOX 88/80,	the death certificate be execut	the attending physician and of Mental Hydiene prior to burit	injury, or other traumatic
TAL RECOR	IICIAN: The law requires that	certificate has been signed by the State Dept. of Health and	, or item 23 shows any
O NOISIAI	TIME OR ATTENDING PHYS	EN DIRECTOR: After this of the control of the contr	T. If Item 28 is marked,
1	TO THE TAN	TO THE FUR be filed with	IMPORTAN

												3	09991
	1 - FOR STATE REGISTRAR	STATE OF N	MARYLAND /	DEPAR					MENTA	L HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE	OF DEATH		$\neg$	3. TIME OF DEATH D
	C	TECANONIE 197	2214 117.01	TID C					MONT	H D	AY.	YEAR	P P
	4. SOCIAL SECURITY NUMBER	USANNE ET	8. AGE (In yrs. In:							R 7 19	93		1 45 M
	THE PERSON NAMED IN		6. AGE (III yrs. III		MONTHS	DAYS	IF UNDER	24 HRS.		OF BIRTH h, Day, Year)		6. BIRTHE	PLACE (State or Foreign
1 8	579-70-1415	1 M 2 F	66	YRS.					AII	G 29 1	926		GERMANY
	9a. FACILITY NAME (If not institution, give a	treet and number)			9b. CIT	Y, TOWN C	R LOCATI	ON OF DE				NTY OF DE	
1 5	NATIONAL NAVAL	MEDICAL	CENTED			D IZ	miro	D. 4					
DIRECTOR	RESIDENCE OF DECEDENT	MEDICAL	CENTER			BE	THES	DA			I M	ONTGO	MERY
l m	10e. STATE 10b. COUNT	Y		10c. CIT	Y, TOWN	OR LOCAT	TON						10d. INSIDE CITY
1 2	MARYLAND AT	NNE ARUNI	)EI			A ATA	A DOT	T.O.					LIMITS?
ابا	10e. STREET AND NUMBER	AKUNI	71:11			_	APOL.				10a CIT		HAT COUNTRY?
FUNERAL	1106					1,500		-			log. or	EEN OF W	INI COUNTRIT
Z	1126 LITTLE 1							2140					D STATES
15	1 Never Married 2 XMarried	12. WAS DECEDEN FORCES? 1	YES 2		13					f? (Specify Yes Rican, etc.)	or No-	14. RACE Black	- American Indian, White, etc.
B	3 Widowed 4 Divorced	IF YES, GIVE W	MAR OR DATES A			1 TYES				, , , , , ,		Specify	
0													WHITE
т ш	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DE	CEDENT'S live kind of a Do NOT us	USUAL (	OCCUPATION during mo.	ON st of working	107	16b	KIND OF BU	SINESS/INC	JUSTRY	
l iii	Elementary/Secondary (0-12)	College (1-4 or 5	+)	. Do NOT us	e retired.,	)							
COMPLET	12	2		но	HSE	WIFE				Home			
Ö	17. FATHER'S NAME (First, Middle, Last)				10000	N	18. MOTI	NER'S NA	ME (First,	Middle, Maiden	Sumame)		
	ERICH WILHELD	d DEMITTE						***				- 77	
BE	19e. INFORMANT'S NAME (Type/Print)	TIEME LE	10	h MAILING	ADDRES	SS (Street a	ad Mumbo			ARD OT			I DANN
9	The contraction of the contracti										n, State, Za	) Code)	
1 3	CHARLES A. WICKER	RS		1126				THY Y	VIEW				21401
	20a. METHOD OF DISPOSITION	oval from State	20b. PLACE cemetery, cre				me of		DAT	E 20c. LO	CATION —	City or Tow	rn, State
	4 Donation 5 Other (Specify)		- Azzli	ngto	n N	atio	onal	Ce	mį.	Ar	ling	ton,	, VA
	21. SIGNATURE OF EUNEHAL SERVICE LIE	DENSEE /	1///		22	NAMEAN	D ADDRE	SS OF FA	CILITY	al Ho	m o	DΔ	
	11/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1	1 / Sound	[]///										4D 21401
$\vdash$	van 1	como	or we.				_				_		10 21401
	23. PART I. Enter the diseases, or shock, or heart failure.	complications the List only one ceu	t caused the de	eath. Dor	ot ente	r the mo	da of dy	ing, suci	h as can	fiac or resp	ratory an	rest,	Approximate Interval Between
	IMMEDIATE CAUSE (Final												Onset and Death
1 1	disease or condition resulting in death)	A TETT A	STATIC	CADCI	MOM	A OF	THE	TIIM	~				
1 1	Totaling in deathy		(QR AS A CONSE			A UF	LHE	LIDIN	7				1
-	_												
ERTIFICATION	Sequentially list conditions,	bDUE TO	(OR AS A CONSE	QUENCE OF	T):				_				
A	If any, leading to immediate cause. Enter UNDERLYING				,-								j
[윤]	CAUSE (Disease or injury	C	(OR AS A CONSE	OUENCE OF	n.								<u> </u>
ΙĒΙ	that initisted eventa resulting in death) LAST	502.10	(OIT AS A CONSE	QUENCE OF	7.								
		d											
	PART II. Other aignificant condition	a contributing to	death but not a	regulting i	n the u	nderiving		aluma in	Dart I	24a. WAS AN	ALITODON	200	WERE ALTERNATION TO A STATE OF
MEDICAL							g cause ;	giveii iii	ranc t.	PERFOR			WERE AUTOPSY FINDINGS MAJLABLE PRIOR TO
ā										1 X YES 2	□ NO		COMPLETION OF CAUSE OF DEATH?
2													1 TYES 2 NO
7													
₹	25. WAS CASE REFERRED TO MEDICAL					26. PL	ACE OF D	EATH (Ch	eck only or	10)			
SICIAN:	EXAMINER?  1 YES 2 NO	HOSPITAL:	ED/Outpetlant 2	□ DO4	OTHE								
РНҮ	27. MANNER OF DEATN	28a. DATE OF		28b. TIM		28c, INJ		sidence					
	1 X Natural 5 Pending	(Month, D		INJ	URY	WO	RK?		28d. DE:	CRIBE HOW I	NJURY OC	CURED	
À	2 Accident Investigation						rES 2	NQ N					
<u>a</u>	3 Suicide 6 Could not be	26a, PLACE O building,	F INJURY — At he etc. (Specify)	me, farm, s	street, fac	ctory, office			26f. LOC	ATION (Street in or Town, State)	ind Number	or Runii Ro	oute Number,
	4 Nomicide determined								_				
OMPLET	29a. CERTIFIER (Check only 1 X CERTIFYING PHYSI	CIAN: To the best of	my knowledge de	oth occurre	d at the	time date	and place	and due	to the ac-	reals) and		ad	
N N	(Check only one) 2 MEDICAL EXAMINE												and manages as at 1 d
응						opmilott, Ot				-ru piace, an	a and 10 (1	- CSUSO(8)	and manner as stated.
B	296. SIGNATURE AND TITLE OF CERTIFIER	3					29c. LICE	NSE NUN	RBER			4 1	(Month, Day, Year)
0		m. m.n.					D-	-427	18		1	4/8/9	3
	30. NAME AND APPRESS OF PERSON WH	O COMPLETED CALE	RE OF OCATA (ITE	M 27) /5-00	D-1-11								

COMPLETED CAUSE OF OEATN (ITEM 27) (Type, Print)

NN. LT. MC. USNR
32, REGISTRAR'S SIGNATURE
GINA DAVIDSON PONDER

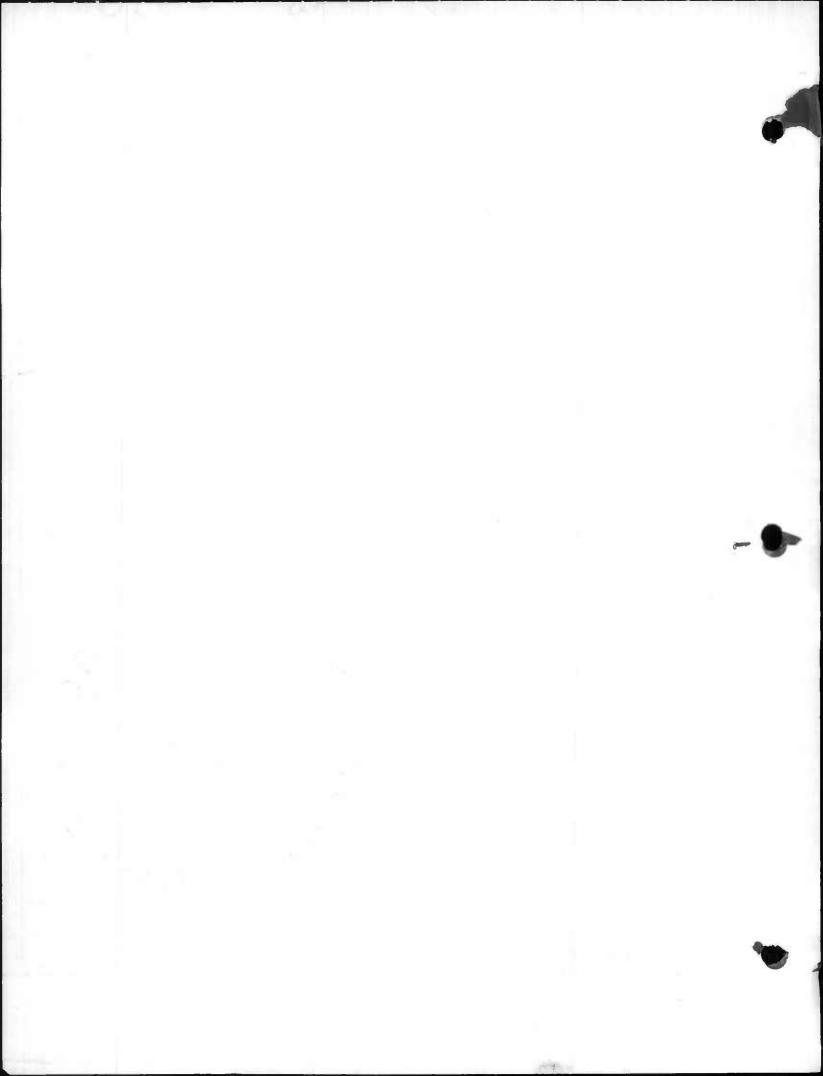
BROWN.

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600



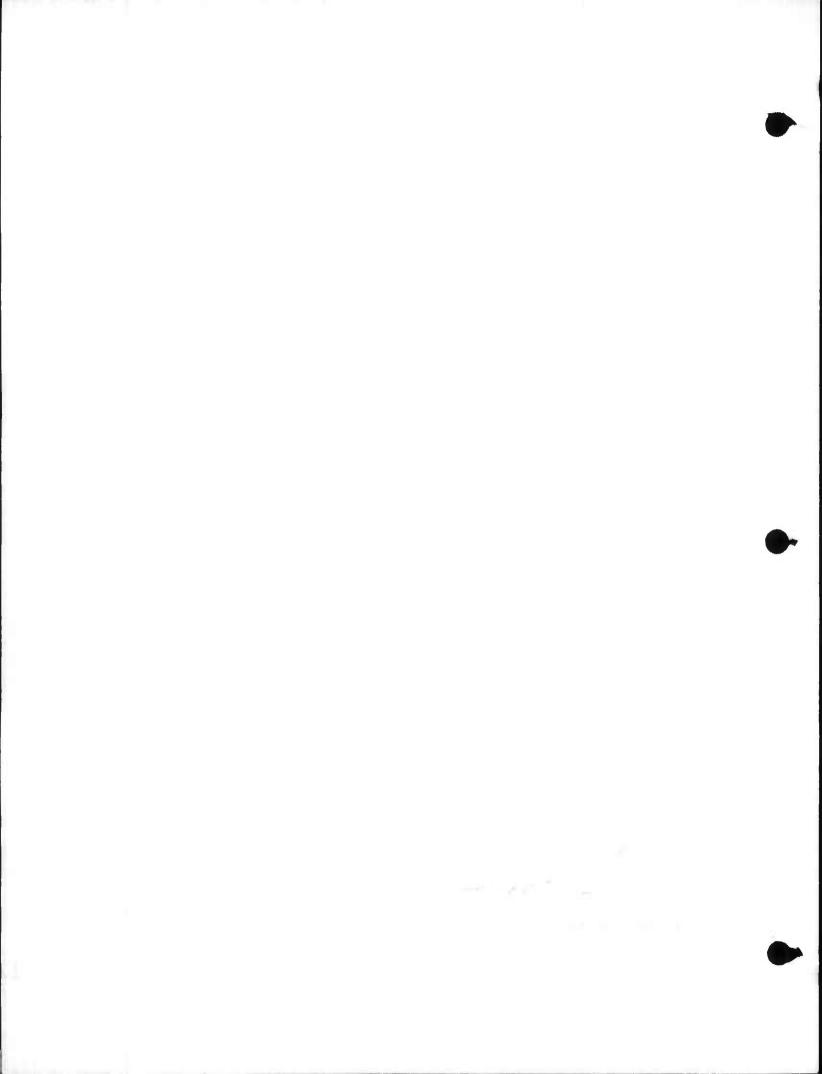
JOHN E. B 31. DATE FILED (Month, Day, Year) APR 0 9 1993



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the bosp TO THE FUNETAL DIFFICURA After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached in many minimal part of the State Dept. of Health and Mental Hygiens prior to burial, cremation, or removal.  IN THE PORTANT. If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical anaminer must be notified at once.
10 10 10 100

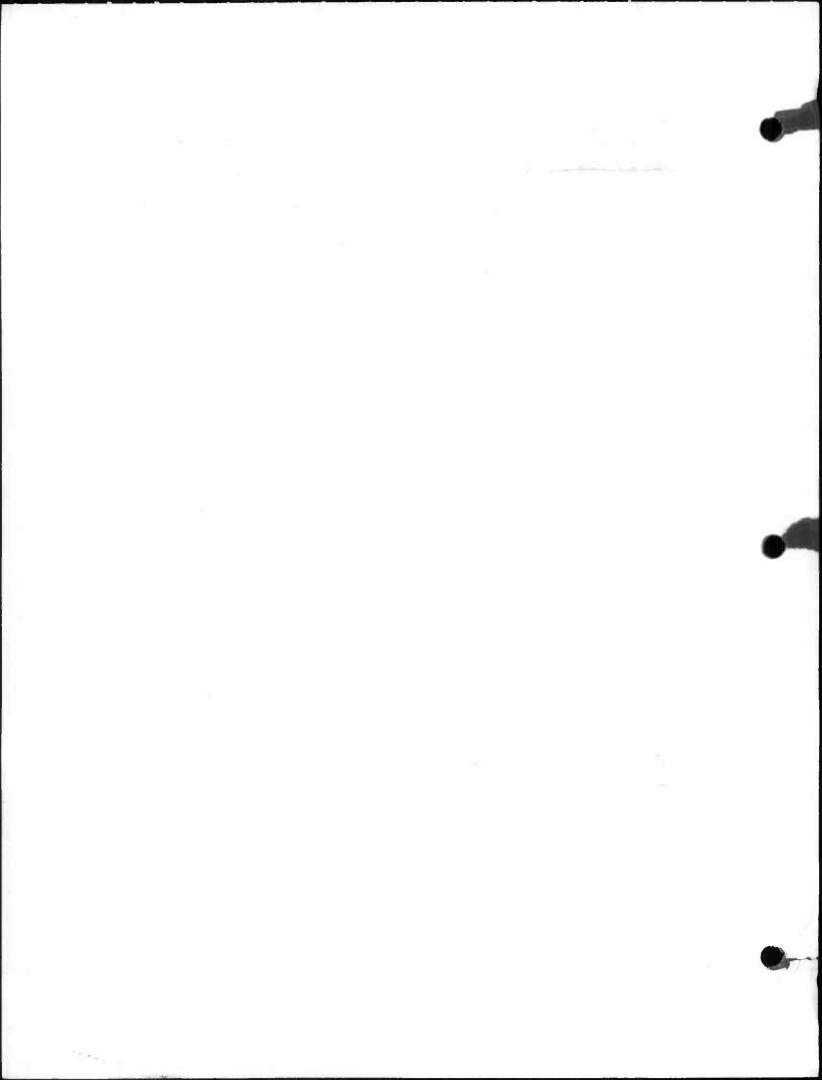
	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	MEO G-6 RTMENT OF I FICATE OF	HEALTH AND			E		03332	
	1. DECEOENT'S NAME (First, Middle, Last)				BEATTI		E OF DEATH		1 :	. TIME OF DEATH	
	MAUREEN	Norton w	EIS			MONT	TH DA	190	YEAR 9.3	3:09 P M	
	4. SOCIAL SECURITY NUMBER		n yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE	7. DATE OF BIRTH 8. BIRTHPLACE (State or Fore Country)				
	070-34-3933		19 YRS.	WOWINS DAYS	HOURS MIN.		-07-4	3 1		York	
000	9a. FACILITY NAME (if not institution, give st			9b. CITY, TOWN	OR LOCATION OF D	EATH		9c. COUN	TY OF OEA	TH	
DIRECTOR	ANNE ARUNDEL RESIDENCE OF DECEDENT 10s. STATE 10s. COUNTY				ANNAPOLIS ANNE ARUND						
	MD Anne	Arundel		thian	rion					0d. INSIDE CITY LIMITS?  YES 2 NO	
FUNERAL	100. STREET AND NUMBER 634 Rosewood Co	ourt			20711			USA	EN OF WH	AT COUNTRY?	
3	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 YES		13. WAS OE	ENDENT OF HISPA	NIC ORIGI	N? (Specify Yea		14. RACE -	- American Indian,	
B≺	1 Never Married 2 Narried 3 Widowed 4 Divorced	2 X NO TES	o If yea, specify Cuban, Maxican, Puarto Rican, etc.)  □ YES 2X□ NO Specify:  Black, White, etc.  Specify: White								
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	ATION	16a. OECEDENT'S	USUAL OCCUPATI	ON	160	b. KIND OF BUS	INESS/INDU	JSTRY		
	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille, Do NOT u		st of working	Ι.					
MP	12	4	Housew	rie		1	Housel	old			
BE CO	17. FATHER'S NAME (First, Middle, Lest) George Norton				18. MOTHER'S NA Elv	ia S	(First, Middle, Malden Surname) a Schneider				
TO B	19a. INFORMANT'S NAME (Type/Print)  Fred J. Weis  19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)  634 Rosewood Court, Lothian, MD 20711										
	20a. METHOD OF DISPOSITION	20b.		OF DISPOSITION (N		DAT		CATION — C			
	MXBurial 2 ☐ Cremation 3 ☐ Ramo 4 ☐ Donation 5 ☐ Other (Specify)	rval from Stata ceme	etery, crematory or o			1					
	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE /	TE OI	22. NAME A	ND ADDRESS OF FA	ACILITY				N Y.	
	23. PART I. Enter the diseases, or combact of head follows	edul		12 R:	esty Fu idgely	Ave	. Anna	poli	s,M	D 21401	
CERTIFICATION	disease or condition resulting in death)  a. AND HEPATIC INVOLVEMENT  DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury									Onset and Death	
ERT	that initiated events resulting in death) LAST										
MEDICAL	PART II. Other significant conditions	contributing to death bu	it not reaulting	in the undariyin	g cause given in	Part I.	24s. WAS AN PERFOR 1 YES 2	S AN AUTOPSY PROPERTY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO			
3	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			26. PI	ACE OF OEATH (C)	neck only o	ne)				
PHYSICIAN:	1 LYES 2 NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpa	itlent 3 🗆 DOA	OTHER: 4 Nursing Horr	e 5 🗆 Residence	6 🗆 Othe	er (Specify)				
동	27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c. INJ			SCRIBE HOW IN	JURY OCCL	JRED		
BY I	Natural 5 Pending   Pending	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			ES 2 NO						
ا م ا	3 Suicide 6 Could not be 4 Homicide determined	— At home, farm,	street, factory, offic		28t. LOC City	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)			te Number,		
COMPLETE	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC CHECK ONLY ONE) 2 CMEDICAL EXAMINES	IAN: To the best of my knowle	and/or immediate	ed at the time, data	and place, and due	to the ca	use(a) and man	ner aa atateo	d.		
	296. SIGNATURE AND TITLE OF CERTIFIER	or average of		ar, in my opinion, d			and place, and				
BE	The Control of the Co	~			29c. LICENSE NUI					Ionth, Day, Year)	
5	30. NAME AND ADDRESS OF REASON WHO	COMPLETED CAUSE OF DEA	TH (ITEM 27) /5-04	Print)	OCN	4E		4	6	1993	
	AMONON		111 Per	nn Stre	et, Bal	ltim	ore,	Mary	land	21201	
	APR 09 1993	32. REGISTRAR'S SIGNA									





BALTIMORE, MARYLAND 21215-0020
TO THE HIGH HILL AND THE MONTHING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremental, or removal.
IMPORTANT: If tem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC			MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Lest)	WAYSON	)			2. DATE OF DEATH		3. TIME OF OEATH	
	219-16-3007			UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country) Maryland	
TOR	HARDOR HOSPI	tal Cente,	C 96	2 11	NIRE		9c. COUNTY	OF DEATH	
DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNTY		10c. CITY, TO	OWN OR LOCATI	ON			10d. INSIDE CITY LIMITS?	
	Maryland Anne	Arundel	Lin	thicum	ZIP CODE			1 TYES 2 NO	
FUNERAL	731 Helen Avenue			100.	21090		USA	OF WHAT COUNTRY?	
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	P. WAS DECEDENT EVER IN FORCES? 1 X YES IF YES, GIVE WAR OR OA WW II	2 NO	It yes, spe	CENDENT OF HISPANIC ORIGIN? (Specify Yes or No—pecify Cuben, Mexican, Puerto Rican, atc.)  14. RACE — American Indian, Black, Whita, atc. Specify: White				
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5 +)  16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)							RY	
MPL	8th		Carpente	2		U.S. Co		ıard	
	17. FATHER'S NAME (First, Middle, Lest)  James Wilbur Wayso	n				ME (First, Middle, Maiden	Surname)		
TO BE	19a. INFORMANT'S NAME (Type/Print)	11	19b. MAILING ADI	DRESS (Street an		. Ireland  Joute Number, City or Town	n, State, Zip Coo	(le)	
ř	Mary B. Wayson		731 He	len Ave	nue, Lir	nthicum, Ma	aryland	21090	
20a. METHOD OF DISPOSITION  1 Date  20b. PLACE AND DATE OF OIS POSITION (Name of cametery, crematory or other place)  Meadowridge Memorial Park 4/10/93 Dorsey, Mary									
	21. SIGNATURE OF FUNERAL SERVICE LICEN	luse , g -		Ambros 2719 H	e Funera ammonds	ul Home of Fr. Rd. La	Lansdown	owne ne, Md. 21227	
	PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feliure. List only one cause on each line.  Approximata interval Between								
	IMMEDIATE CAUSE (Finel disease or condition resulting in death)			CAR.	DIAL	INFAR	LC710	Onset and Death	
z		DUE TO (OR AS A	CONSEQUENCE OF):						
ATIO	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):						
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events	DUE TO (OR AS A	CONSEQUENCE OF):						
ERT	resulting in death) LAST								
AL C	PART II. Other algnificant conditions of	contributing to deeth bu	it not reculting in th	ne underlying	ceuee given in	Pert I. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS	
MEDIC	CoRUNAR	/	9 PH	E171	ح	1 YES 2	MLD!	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
	/ TAPEICIEN	N012C				-   '		1 YES 2 NO	
PHYSICIAN:	S. WAS CASE REFERRED TO MEDICAL V	/			CE OF DEATH (Che	ck only one)			
IVSI	YES 2 NO	OSPITAL:  Inpetient 2 ER/Output	itlant 3 DOA 4			8 Other (Specify)	_		
	27 MANNER OF DEATH  1 Natural 5 Pending	(Month, Day, Year)	28b. TIME OF	WOF	RY AT IK? ES 2 NO	26d. DEŞCRIBE HOW II	JURY OCCURE	ED	
ED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28s. PLACE OF INJURY building, etc. (Speci	At home, farm, stree			261. LOCATION (Street a City or Town, State)	nd Number or R	lural Route Number,	
lel le	29%. CERTIFIER 1 CERTIFYING PHYSICIA	N: To the best of my knowle	idge, death occurred at	the time date of	and place, and due	to the causele) and men			
COMPLETED								use(a) and menner as stated.	
BE	29b/SIGNATURE AND TITLE OF CERTIFIER	Alte	'nding		29c. LICENSE NUM	9ER 776	29d DATE SIG	INED (Month, Day, Year)	
5	30, NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEA	TH (ITEM 27) (Typo, Prin	D 3 E	PAT	APSCO F	W. 2	ATMORE 1) 2/2/1	
	31. DATE FILED (Month, Day, Year) ADD 0 9 1993 July	32 DEGISTRAR'S SIGNA	de la company				,	7	



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

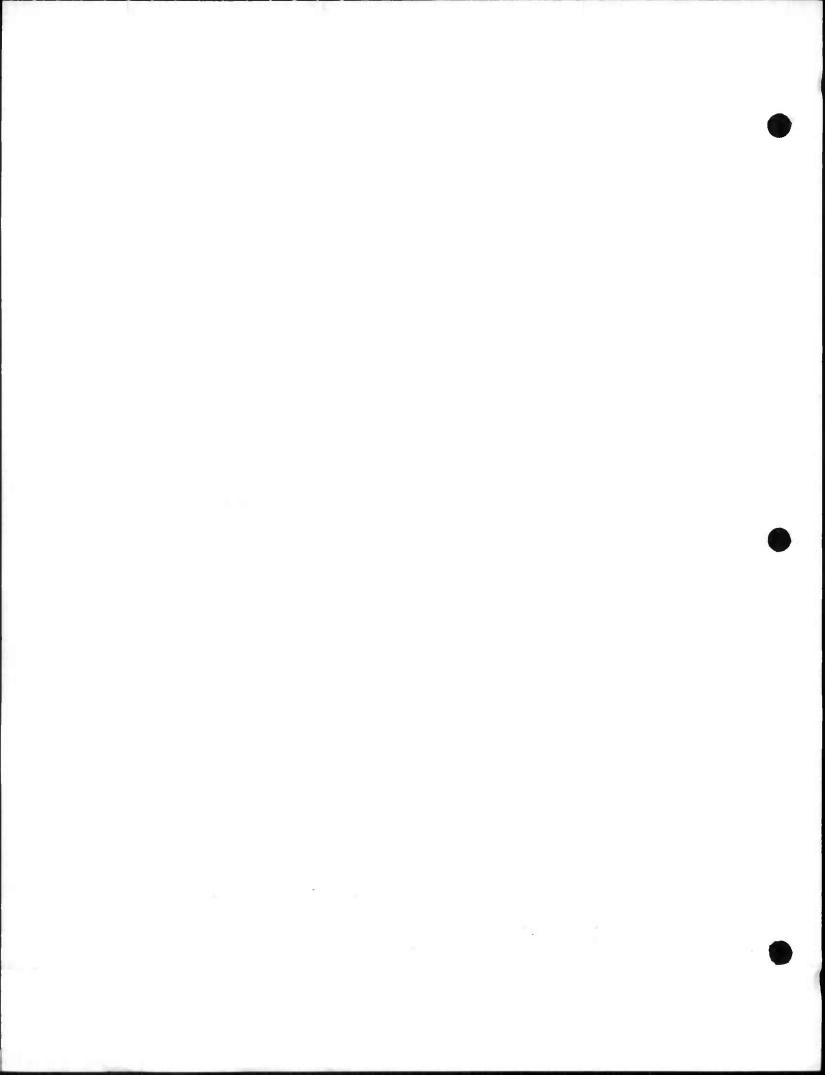
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IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

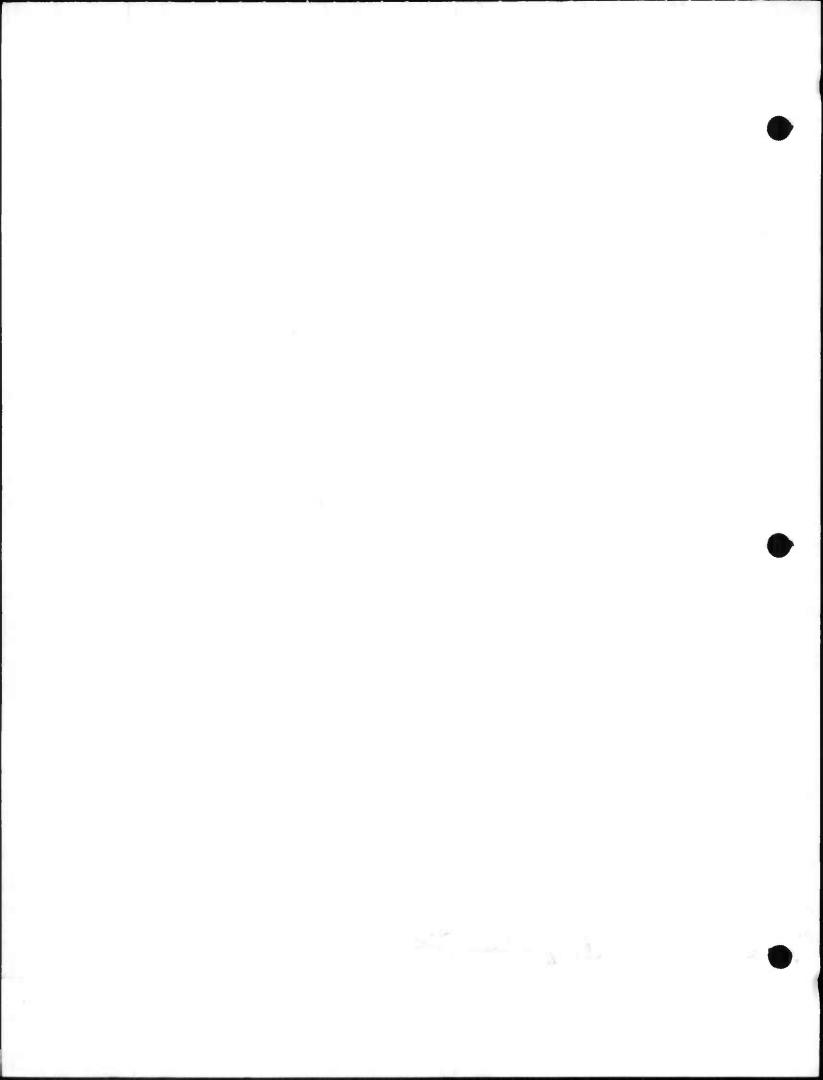
FOR

	1 - STATE REGISTRAR	01 11111111		ICATE OF		MENIAL	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE O	F DEATH			3. TIME OF DEATH
	THOMAS JEFFE	RSON	V	OODY		04	06		93	12:20 AM M
	4. SOCIAL SECURITY NUMBER 5. SEX		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HR	40.0	F BIRTH Day, Year)		6. BIRTH	PLACE (State or Foreign
	215-07-4499 1 XM 2		81 YRS.	MONTHS DAYS	HOURS MIN	06-07	7-1911		Countr	RGINIA
_	9a. FACILITY NAME (If not institution, give street and num	iber)		9b. CITY, TOWN	OR LOCATION OF	DEATH		9c. COU	NTY OF D	EATH
6	NORTH ARUNDEL HOSPITA	L ASSO	CIATION	GLEN	BURNIE				A.A.	COUNTY
<u> </u>	10e. STATE 10b. COUNTY		10c CIT	Y TOWN OR LOCA	TION					10d. INSIDE CITY
DIRECTOR	MARYLAND NONE		1.00	BALTI	BALTIMORE LIMITS?					
	10. STREET AND NUMBER			10	I. ZIP CODE	<del></del>		10a CIT	IZEN OF W	YHAT COUNTRY?
FUNERAL	6517 GLENOAK AVENUE				21214				S.A.	THAT COUNTRY?
S	11. MARITAL STATUS 12. WAS D	CEDENT EYER I	N U.S. ARMED	13. WAS DEC	ENDENT OF HIS	PANIC ORIGIN?	(Specify Yes	or No-	14. RACE	- American Indian
ВУ F	1 Never Married 2 Married FORCE	S? 1 XYES	2 NO	If yes, sp	ecify Cuben, Mes 2 🕞 NO Spi	rican, Puerto Ri	can, etc.)		Black Speci	— American Indian, t, White, etc.
					X					ITE
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)		(Give kind of a	USUAL OCCUPATE	ON est of working	16b. F	CIND OF BUS	ENESS/INC	DUSTRY	
빑	Elementary/Secondary (0-12) College (1 12 NON		life. Do NOT us			M-	NELSC	N BA	RNES	
WE	17. FATHER'S NAME (First, Middle, Last)	E	PLUM	BER						
	THOMAS WOODY				18. MOTHER'S	NAME (First, Mic			DII	
BE	19a. INFORMANT'S NAME (Type/Print)		10h MAII ING	ADDRESS (Street a		L.		WOO		
5	MRS. ELIZABETH BIEKER			GLENOAK						1.4
	20a. METHOD OF DISPOSITION	201	. PLACE AND DATE			DATE		CATION -		
	1 ☐ Burlel 2 ☐ Cremation 3 ☐ Removat from S 4 ☐ Donation 5 ☐ Other (Specify)	cer.	netery, crematory or or ETRO CRE	ther place)		4/7/				MARYLAND
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		A CKI		D ADDRESS OF	FACILITY				
	I + Jamie 6	:le	X	1 SECO	ND AVE	C W	INGLE	TON	FUNE	RAL HOME
	23. PAHT I. Epfer the diseases, or complication	ns that cause	d the death. Do r	anter the me	de el debe e	, S.W.	, GLE	N BO	RNIE	, MD.21061
W.	anock, or neart reliure. List bnly o	ne cause on e	ech line.	enter the mo	de or dying, a	den ea estan	c or respii	ratory an	rest,	Approximsta Interval Between
	IMMEDIATE CAUSE (Final disease or condition	1000	111-	^ .						Onset and Death
	resulting in death)	DUE TO (OR AS	CONSEQUENCE OF	i		-/	-			
Z	Conserve ho- 8t talle									
CERTIFICATION	if any, lesding to immediate	DUE TO (OR AS	CONSEQUENCE OF	7:					-	
2	cause. Enter UNDERLYING CAUSE (Disesse or Injury	4 (	CONSEQUENCE OF	) <u>(</u>	eld	M				
Ē	that initiated events resulting in death) LAST	O A	CONSEQUENCE OF	1 -	10	. / .	1	<b>,</b> ,		
E	d.				NV	nei	me	1	)	
11	PART II. Other algnificent conditions contribute	ing to death b	ut not resulting	n the underlying	ceuse given	In Part I. 2	4a. WAS AN		24b.	WERE AUTOPSY FINDINGS
DICAL	to tube	tee	de	P			PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
ME	Alterroso	les.	osci							1 YES 2 NO
ä										
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	M ·		26. PL	ACE OF DEATH	Check only one)				
YSI	1 YES 2 NO 1 Inpette	nt 2 - ER/Outs	etlent 3 DOA	4 Nursing Hom	e 5 🗆 Residenc	a 6 🗆 Other (	Specify)			
표		ATE OF INJURY lonth, Day, Year)	28b. TIM		URY AT RK?	20d. DESC	RIBE HOW IN	JURY OCC	CURED	
B	2 Accident Investigation	****			ES 2 NO					
8	3 Suicide 6 Could not be 4 Homicide determined	illding, etc. (Spec	— At home, farm, a	treet, tactory, offic		281. LOCAT City or	tON (Street as Town, State)	nd Number	or Rural R	oute Number,
COMPLETED	29e. CERTHIER									
MP	(Check only 1 CERTIFYING PHYSICIAN: To the	best of my know	ledge, death occurre	d at the time, date	and place, and d	lus to the cause	e(a) and man	ner sa stat	ed.	
8	2 MEDICAL EXAMINER: On the ba	na or axaminatio	n and/or investigatio	n, in my opinion, d			nd place, and	due to th	a cause(a)	and manner as stated.
BE	29b. SIGNATURE AND TITLE OF CERTIFIER		X	/	29c. LICENSE N		0.10	29d, DATI	SIGNED	(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETE	O CALIGE OF DE	ATH (ITEM TO ITEM	SIM	~ 72	206	91/11/4		7 (	) / >
				DADM DO	AD / ADM	VI D 144	י זעת	D 0	1010	
	MUSTAFA C. OZ. M.D./	2/3-B P	ENINSULA ATURE	FAKM RU	AD/ ARNC	JLU, MA	KILAN	ע 2.	1012	
	APR 0 9 1993	Deut dan	Mande se							



(		
BALTIMORE, MARYLAND 21215-0020	ifter death. Page 6 may be retained by the hospital or attending physician. the funeral director, page 5 should be detached for use as the burial-tran oval.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician.  JO THE FUNEAL ORECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans permits be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.  IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medbel examiner must be notified at once.	

	REGISTRAR		CE	ERTIF	CATE OF	DEATH	REG	i. NO.		
	t. DECEDENT'S NAME (First, Middle, Last)			T-T -			2. DATE OF OE	ATH DAY	3. TIME OF OEATH	
			eroy		rrell		04	01 199	3 9:40 P. M	
		5. SEX 6.	AGE (In yrs. less	t birthday) _ YRS.	MONTHS DAYS	HOURS MIN.	7. DATE OF BIRT (Month, Day, Y 9-15-3	bar)	B. BIRTHPLACE (State or Foreign Country) Virginia	
	9a. FACILITY NAME (If not institution, give street	et and number)			9b. CITY, TOWN	OR LOCATION OF D			TY OF DEATH	
DIRECTOR	Liberty Medical Center Baltimore City									
Ĕ	toe. STATE tob. COUNTY			10c, CITY	TOWN OR LOCA	TION			10d. INSIDE CITY	
	Maryland  100. STREET AND NUMBER				Baltimo				LIMITS?  1 TY YES 2 NO	
FUNERAL	2308 Tioga park					21215			EN OF WHAT COUNTRY?	
BY FU	11. MARITAL STATUS  t Never Married 2 Married  3 Widowed 4 Divorced	VER IN U.S. ARI YES 2 TAN OR DATES	NO If yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, Wh							
	15. DECEOENT'S EDUCATION (Specify only highest grade completed)  16a. DECEDENT'S USUAL OCCUPATION (She kind of work done during most of working)  16b. KIND OF BUSINESS/INDUST							Black STRY		
COMPLETED	Elementary/Secondary (0-12) 7th.Grade	ilfe.	Do NOT use	Labore			Cong	truction		
8	17. FATHER'S NAME (First, Middle, Last)			_	пароте				truction	
BE C		rrel1				18. MOTHER'S NA	ME (First, Middle, A	uzzell		
2	19a. INFORMANT'S NAME (Type/Print)					and Number or Rural				
	Kim E. King								, MD 21215	
	20e. METHOD OF DISPOSITION t □ Buriel 2 XCremation 3 □ Remove 4 □ Donation 5 □ Other (Specify)		cemetery, crer	natory or oth	FOISPOSITION (N	atory.	THIC. 4	6 Ra	ty or Town, Stata	
	21. SIGNATURE OF FUNERAL SERVICE LICEN	Ronald	Wade.	Dir	22. NAME A	ND ADDRESS OF FA			my Board	
	Mmul//	Moor	4/5	/93	655 1	V.Baltimo				
	23 PART I. Enter the diseases, or con	mplications that ca	used the dea	ath. Do no						
	shock, or neert failure. Lie	ersive Ather	on eech line.		ı				Interval Between Onset and Death	
	// a	DUE TO (OR	AS A CONSEO	UENCE OF		00.00				
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR	AS A CONSEO	UENCE OF	:					
FICA	cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted events	DUE TO (OR	AS A CONSEO	UENCE OF						
H	resulting in desth) LAST									
2	PART II. Other significant conditions of	nontribution to de-	oth had not -							
EDICAL	And the organicant conditions t	contributing to det	ath but not re	esulting in	the underlyin	g cause given in	PI	AS AN AUTOPSY ERFORMED? ES 2 NO	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
ME							_   ~		1 YES 2 NO	
ž										
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:			26. P	ACE OF OEATH (Ch	eck only one)			
ΙŁS	t 🗗 YES 2 🗌 NO 1	☐ Inpatient 2 ER		□ DOA	4 - Nursing Hon	e 5 🗆 Residence				
ВУ РН	1 Netural 5 Pending	28a. DATE OF INJ (Month, Day, Y	bar)	28b. TIME INJU	RY WO	URY AT PRK? YES 2 NO	28d. DEŞCRIBE I	10W INJURY OCCU	RED	
	2 Accident Investigation 3 Suicide 6 Could not be determined	28s. PLACE OF IN building, etc.	JURY — At hon (Specify)	ne, ferm, st	reet, factory, offic	•	281. LOCATION (S City or Town,	Street and Number of State)	Rural Route Number,	
	an Operation									
COMPLETED	(Check only								cause(a) and manner as stated.	
BE C	29b. SIGNATURE AND TITLE OF CERTIFIES	1 11				29c. LICENSE NUI			BIGNED (Month, Day, Year)	
		11 // //								
	Verno	J. Chi	fi un			O.C.M	E.	<b>&gt;</b> (	04/02/1993	
TO B					-	O.C.M et, Bal			04/02/1993	



93

9c. COUNTY OF DEATH

3. TIME OF DEATH

AM

4:35

8. BIRTHPLACE (State or Foreign Country) New York

10d. INSIDE CITY LIMITS? XXVES 2 NO

14. RACE — American Indian, Black, White, etc.

Approximate

PRINCE GEORGE'S

4. SOCIAL SECURITY NUMBER

023 14 8223

HILDA

YRS.

IF UNDER 1 YEAR

DAYS

MONTHS

IF UNDER 24 HRS.

003

BONIE

SURGRIOR

323

HOURS

ALDRIDGE

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32 ACCUSTANT SONATURANDO

MO

86

6. AGE (In yrs. last birthday)

17

2. DATE OF DEATH MONTH 03 1

7. DATE OF BIRTH

(Month, Day, Year)

March 6 1907

S 50		- 1	99. PACIEITY HAME (II not institution, give :	street and number)	- 1	96. CITY, TOWN (	OR LOCATION OF DEATH	9	c. COUNTY	OF DEATH
The contract of		DIRECTOR	PRINCE GEORGE'S HO	OSPITAL CENT	TER	CHEV	FRLY		PRINC	E GEORGE t
		5 1	RESIDENCE OF DECEDENT						1 1/21/40	DE GEORGE
Se (Septiment)		# I	10e. STATE 10b. COUNT		10c. CITY,	TOWN OR LOCAT	TION			10d. INSIDE CITY
		ᅙ	Maryland Princ	ce George's	Boy	wie				XXVES 2
pe-mir.		7	10e. STREET AND NUMBER			101	. ZIP CODE	10	g. CITIZEN	OF WHAT COUNTRY?
			12301 Rolling H:	ill Lane		- 1.	20715		Unite	d States
-0020 ing physician. the burial-transit		FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED	13 MMS DEC	ENDENT OF HISPANIC O			RACE — American India
)20 Ohysia			1 Never Married 2 Married	FORCES? 1 YE	S 2 NO	If yes, sp	ecify Cuban, Mexican, Pu	erto Rican, etc.)	1 2	Black, White, etc.
BALTIMORE, MARYLAND 21215-0020 er death. Page 6 may be retained by the hospital or attending physician the funeral director, page 5 should be detached for use as the burial-tra		à	3XXWidowed 4 ☐ Divorced	IF YES, GIVE WAR OR	No.	1 _ YES	2XX NO Specify:	No		SpecMy: White
ttendi			15. DECEDENT'S EDU	CATION	16a. DECEDENT'S L	JSUAL OCCUPATION	ON	16b. KIND OF BUSINE	SS/INDUSTI	RY
212 or a		E	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4 or 5 +)	(Give kind of we	ork done during mo retired.)	at of working			
D spital		ᆲ	12	Consign (1-4 or 5 +)	Homemak	er		Own Hom	e	
N by Page	once.	COMPLET	17. FATHER'S NAME (First, Middle, Last)				16 MOTHER'S NAME /	First, Middle, Maiden Sun		
7 5 8	, t		Knute William He	dherg			Hilda Er			
Bad bed	9	<b>8</b>	19a. INFORMANT'S NAME (Type/Print)		105 MAIL ING	ADDRESS (Object)	and Number or Rural Route		-	
MARYLAND 2121 retained by the hospital or atti	notified at	임	Herbert J. Burrow	TC.						
age age							ing Hill La			
BALTIMORE, ter death. Page 6 may be the funeral director, page	must be		20a. METHOD OF DISPOSITION 1XXBurial 2 □ Cremation 3 □ Plant		ob. PLACE AND DATE OF emetery, cremetory or oth		rma of	DATE 20c. LOCAT	ION — City	or Town, State
M C	Ē		4 Donation 5 Other (Specify)			11s Ceme	tery 3/22	7/93 Jami	ca Pl	ain Mass
T a m	를		21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE			D ADDRESS OF FACILIT			
AL death	- wax	- 1	* KAPLENT E	Comma	Paga		L1-Evans Fι			
	or removal. medical examiner		23. PART I. Enter the diseeses, or	complications that caud	ed the death Do no	t enter the mo	00 Annapoli	s Rd Row	ie Md	20715   Approxima
A hours of filled in by	ned a		shock, or heart fellure.	List only one cause on	each line.	or enter fire inc	de or dying, such as	cerdiac or respirate	ny arrest,	Interval B
# 54 F			IMMEDIATE CAUSE (Finel disease or condition	0	1 -	5%	/			Onset and
thin thin	cremation,		resulting in death)		, tic	2000	×			36
P.O. BOX 68760, and certificate be executed within thending physician and completely	- 6			DUE TO JOR'S	A CONSEQUENCE OF	,	٨			
ecute Becute	atic ev	z I	Sequentially list conditions,	h My	lo fre	rear	2			54
De ex cian a	S E	ĔI	If any, leading to immediate	DUE TO LOW AL	A CONSEQUENCE OF	k.				
BO afte t	r trau	፩	cause. Enter UNDERLYING CAUSE (Disease or Injury	C						
O Preint	Hygiene or other	CERTIFICATION	that initiated events	DUE TO (OR AS	A CONSEQUENCE OF)	:				11.11
P. Cal	P P		resulting in death) LAST	d						
RECORDS, P.O. BOX requires that the death certificate be een signed by the attending physician	of Health and Memai Hygiene prior to buna shows any injury, or other traumatic		PART II. Other eignificent condition	as contributing to death	but not requition to	the condensate			4004	
ORD that the	and in	MEDICAL	ondiano.	- Contributing to destil	bot not resulting in	i the underlyin	g couse given in Part	I. 24s. WAS AN AUT PERFORME		24b. WERE AUTOPSY FI AMAILABLE PRIOR
O to par	and and	ă						1   YES 2	NO	COMPLETION OF CO
RECC requires	OW!	¥								1   YES 2
L RE	23 sh	ż								
TAL The lav	State Dept.	₹ I	25. WAS CASE REFERRED TO MEDICAL			26. PI	ACE OF DEATH (Check o	nly one)		
F VIT, SICIAN: The certificate	State D	PHYSICIAN:	EXAMINER? 1 YES 2 NO	HOSPITAL:		OTHER:	e 5 Residence 6 🗆	Other (Specify)		
OF VIPPINGLAN:	o the	<b>≟</b> ∥	27. MANNER OF DEATH	28a. DATE OF INJUR	Y 28b. TIME	OF 28c. INJ	URY AT 28d	DESCRIBE HOW INJU	RY OCCURE	D
P S	nrked,		1 Natural 5 Pending	(Month, Day, Year	) INJU	JRY WO	RK7 YES 2 NO			
ONING	death ma	à	2 Accident Investigation 3 Suicide 8 Could set be	28e. PLACE OF INJUI	RY — At home, ferm, st			LOCATION (Street and	Mumbar as P	and Doub Mumber
VISION ATTENDING ECTOR: After		ETED	4 Homicide 8 Could not be	building, etc. (S)	pecify)	motory, othe	201	LOCATION (Street and City or Town, State)	vurnuer of M	urai noute Number,
DIVISION OF VITAL RECORDS, OR ATTENDING PHYSICIAN: The law requires that the dea DIRECTOR: After this certificate has been signed by the at	EE		29a. CERTIFIER							
0 0 0	2 = 3	ブ	CERTIFYING PHYS	ICIAN: To the best of my kno	owledge death occurred	d at the time date	and place, and due to the	e cause(s) and manne		

Ρ.

1 □ M 2 🎞Œ

5. SEX

IMMEDIATE CAUSE (Finel	List only one cause on each line	в.					Interval Between Onset and Death		
disease or condition resulting in death)	- Septio	5	hock				36 How		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	b. DUE TO (OR AS A CONSE  C. DUE TO (OR AS A CONSE	QUENCE OF:	esce son's				Syra		
that initiated events resulting in death) LAST	JOE 10 (ON AS A CONSE	GOENGE OF):							
PART II. Other eignificent condition	ns contributing to deeth but not	resulting In the u	inderlying couse given in	n Part I.	24a, WAS AN AUTOPSY PERFORMED? 1 YES 2 1 NO	CO OF	RE AUTOPSY FINDINGS ALABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO		
25. WAS CASE REFERRED TO MEDICAL			26. PLACE OF DEATH (C	heck only on	10)				
EXAMINER?  1 YES 2 NO	HOSPITAL:  OTHER:  1 Lampetient 2 ER/Outpetient 3 DOA 4 Norsing Home 5 Residence 6 Other (Specify)								
27. MANNER OF DEATH  1 W Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)  28b. TIME OF INJURY AT WORK?  M 1 YES 2 NO			28d. DES	PEŞCRIBE HOW INJURY OCCURED				
3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				OCATION (Street and Number or Flural Route Number, Ity or Town, State)				
enel	ICIAN: To the best of my knowledge, de ER: On the basis of examination and/or						d manner ea stated.		
296. SIGNATURE AND TITLE OF CERTIFIE	hollo.	1 11	29c. LICENSE NU	JMBER		SIGNED (MO	onth, Day, Year)		

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior? THE FUNERAL OF THE FUNERAL DE MITTEL THE FUNERAL DE MITTEL THE MITTEL THE MITTEL THE MITTEL THE MITTEL THE MITTEL THE MITTEL THE MITTEL THE MITTEL THE MITTEL THE MITTEL THE MITTEL THE MITTEL THE MITTEL THE MITTEL THE MI

COMPLETED

BE

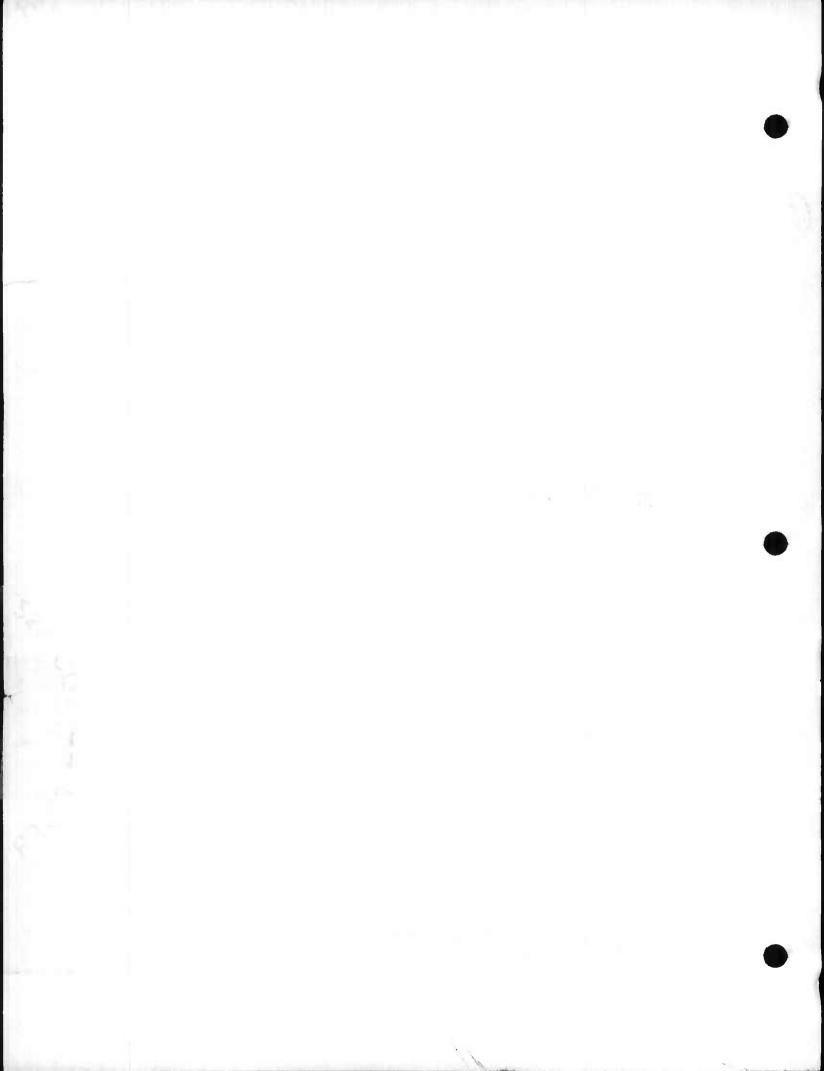
2

LEONARD

APPEL

DHMH-16 Rev 1/89

207/5



1	-	STATE REGISTRAR

TO BE COMPLETED BY FUNERAL DIRECTOR

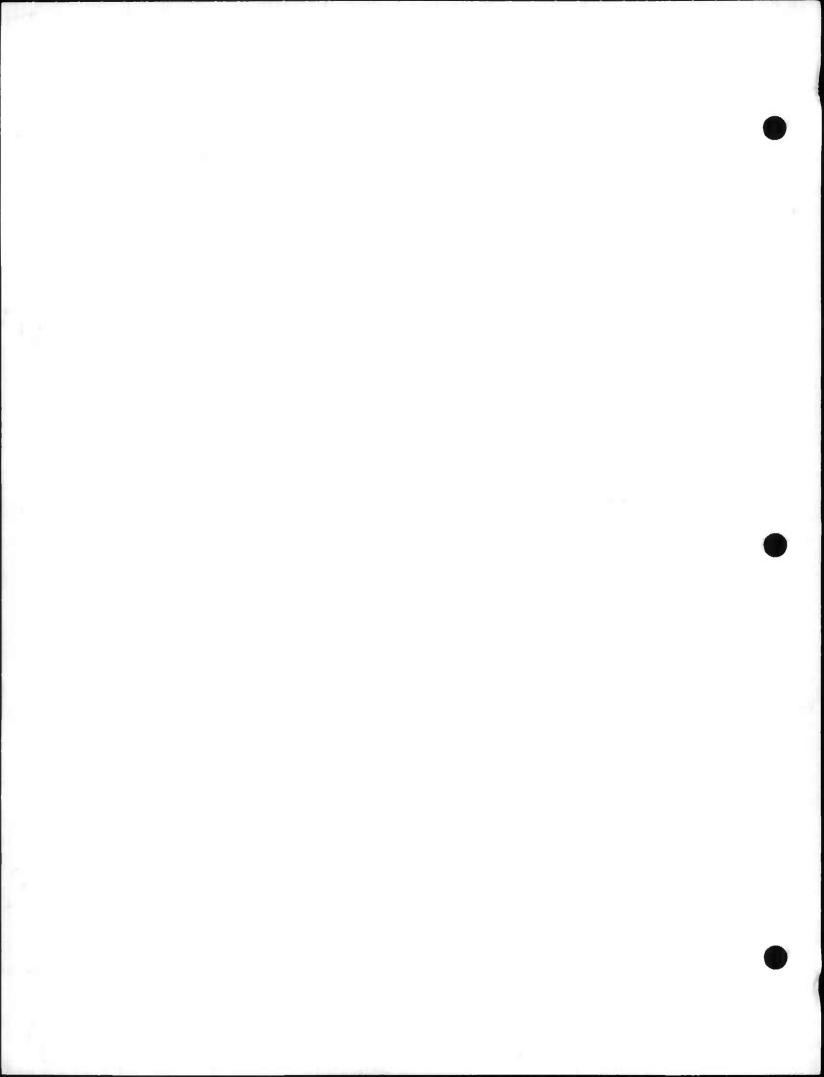
1 - STATE REGISTRAR	SIMIE UF MIANT	CERTIFI				MENIAL HYGIE REG. N					
1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH			3. TIME OF DEATH		
Marty David	Anderson					3	DAY	YEAR S	5:40 A M		
4. SOCIAL SECURITY NUMBER		E (In yrs. last birthday)	IF UNDER 1 YEAR	_		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTI	IPLACE (State or Foreign		
565-52-4160	†∰M 2 □ F	53 YRS.	MONTHS DAY	HOURS	MIN.	Dec. 29,			mesota		
9e. FACILITY NAME (If not institution, give str	eet and number)		9b. CITY, TOW	N OR LOCATI	ON OF DE	ATH	9c. C0	UNTY OF D	DEATH		
Greater Laurel-Be	ltsville Ho	spital	Laure	L			Pri	nce (	George's		
RESIDENCE OF DECEDENT  100. STATE 10b. COUNTY		Inc CITY	TOWN OR LO	TOWN OR LOCATION 164 INSIDE CITY							
Manual and Dadana	C 1 -			JAI TON					10d. INSIDE CITY LIMITS?		
Maryland Prince	George's	Chev	erly	10f. ZIP CODE 10g. CITIZEN OF					1 TES 2 NO		
2202 (2004)											
2302 Crestlawn Av	12. WAS DECEDENT EVER	R IN U.S. ARMED	13, WAS 0	20785 United States  13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No.— 14. RACE — American Indian							
1 XXNever Married 2 Married	FORCES? 1 VE	S 2 NO	If yes,	specify Cubs	n, Mexica	n, Puerto Rican, etc.)		Blec	k, White, etc.		
3 Widowed 4 Divorced	1963-1981		XX						Specify: White		
15. DECEDENT'S EDUC (Specify only highest grade of	ATION completed)	16a. DECEDENT'S U			107	16b. KIND OF BUSINESS/INDUSTRY					
Elementary/Secondary (0-12)	College (1-4 or 5+)	We. Do NOT use	(Give kind of work done during most of working New Do NOT use retired) Liceraft/Ayionics Aviatio								
	6	Maintain	ce/Pro	fesso							
17. FATHER'S NAME (First, Middle, Last)						ME (First, Middle, Maid	ien Surname,				
Arther Anderson  19a, INFORMANT'S NAME (Type/Print)				_		. Marty	<u>.</u>				
Salari Salari Corporat A salari A						Route Number, City or 1		(ip Code)			
J.R. Scott					2.,	Cheverly,		2078.			
1 X Burial 2 Cremation 3 Remo	val from State	ob. PLACE AND DATE Of emetery, crematory or oth	er place)		0.1		LOCATION -	,	,		
4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LICE		<u>Cheltenham</u>		AND ADDRE			elter	ham,	Maryland		
JT/	25					Tuneral H	ome,	Inc.,	3401		
1. Garon	ogn		B1ad	ensbur	g Ro	l., Brent	wood,	MD			
23. PART i. Enter the diseases, pr cr shock, or heart failure. L iMMEDIATE CAUSE (Final disease or condition	omplications that causiat only one cause on	ed the death. Do no each fine	ot enter the r	node of dy	ng, suci	h as cardiac or res	spiratory a	rrest,	Approximate interval Between Onset and Death		
resulting in death)	DUE TO IOR AL	A CONSEQUENCE OF	1	uy	w	1) 0	me	29	JATI.		
_	ra 1	2 1/200	1	01.	200	- 1	1		,		
Sequentially list conditions, if any, leading to immediate	DUE TO (OR AL	A CONSEQUENCE OF		1	rigio	000	10	we	7		
cause. Enter UNDERLYING CAUSE (Disease or injury	( Engly	read	)	ولديا	no	rows	001	se	el l		
that initiated events	DUM TO 10th As	A CONSEQUENCE OF	/ /		- 2	1.		0.020	0		
resulting in death) LAST	DNe	umoth	onex	2.	Se	donde	4	Co	maliali		
PART II. Other significant conditions	contributing to death	but not resulting in	the underly	ing cause o	iven in	Part I. 24s. WAS	AUTOPS	1 246	. WERE AUTOPSY FINDINGS		
			-			rest	ORMED?		MAILABLE PRIOR TO COMPLETION OF CAUSE		
						1   YES	2 X NO		OF DEATH?		
						-			1 TYES 2 NO		
25. WAS CASE REFERRED TO MEDICAL			26.	PLACE OF D	EATH (Ch	eck only one)					
	HOSPITAL:		OTHER:		All	6 Other (Specify)					
27. MANNER OF DEATH	28e. DATE OF INJUR	Y 28b. TIME	OF 28c. I	NJURY AT		28d. DESCRIBE HOY	V INJURY O	CCURED			
1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year	) livin		WORK? YES 2	] NO						
3 Suicide 8 Could not be	reet, factory, of	fice		281. LOCATION (Street	et and Numb	er or Rural I	Route Number,				
4 Homicide determined	building, etc. (S)	occity				City or Town, Sta	re)				
29a. CERTIFIER (Check only	IAN: To the beat of my kn	owledge, death occurred	at the time, d	ate end place	and due	to the cause(e) and n	nenner as s	ated.			
one) 2 MEDICAL EXAMINER									e) and menner as stated.		
296. SIGNATURE AND TUNE OF CENTIFIER	-0			-	NSE NUN		-		(Month, Day, Year)		
Cha?	Ofe,	ans	2	1	-19	496			14, 1993		
30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF	DEATH (ITEM 27) (Type, I	Print)		<i>f</i> /	- 10					
Jai S. Cho, M.D.,	14333 Laur	el-Bowie	Rd., #:	206, I	aure	el, Maryl	and	20708	3		
A DATE SHED ALL A D. W.									· .		
MAR 2 3 1993.	32. REGISTRAR'S SK	MATURE Mandell	,								

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2s nours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEPAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IMPORTANT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



TO BE COMPLETED BY FUNERAL DIRECTOR

FLORIS ANNA  ANDELSON  MONTH DAY YEAR  OS  4. SOCIAL SECURITY NUMBER  5. SEX  8. AGE (In yrs. last birthday) F UNDER 1 YEAR  F UNDER 24 HRS.  OS  1 — M 2 — F 73  YRS.  F UNDER 24 HRS.  OS  1 — M 2 — F 10 —	OF DEATH
FLORIS ANNA  ANDELS UN MALCH 22, 163 OS  4. SOCIAL SECURITY NUMBER  5. SEX  6. AGE (In yrs. last birthday)  73 YRS.  6. AGE (In yrs. last birthday)  73 YRS.  73 YRS.  74 PUNDER 24 RRS.  75 DATE OF BIRTH (Morth, Day, Vear)  12-13-1919  73 Maryla  96. COUNTY)  96. COUNTY OF DEATH  75 PENTANCILLA DECLORAL ACTIVITIES  96. COUNTY OF DEATH	
4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 73 YRS.  6. AGE (In yrs. last birthday) 73 YRS.  6. AGE (In yrs. last birthday) 73 YRS.  73 YRS.  74 F UNDER 24 HRS. 75 DATE OF BIRTTH (Month, Day, Year) 75 MRN.  76 DATE OF BIRTTH (Month, Day, Year) 76 PARTY 12 PROJECT ON A T. ACTIVITIES  8. BIRTHPLACE (S. Country) 73 YRS.  8. BIRTHPLACE (S. Country) 73 YRS.  8. BIRTHPLACE (S. Country) 74 PARTY 12 PROJECT ON A T. ACTIVITIES  96. CITY, TOWN OR LOCATION OF DEATH  96. COUNTY OF DEATH	307 M
214-80-9550 1 M 2 M 7 73 YRS. MONTHS DAYS HOURS MRN. 12-13-1919 Maryla  9a. FACILITY NAME (II not institution, give street and number)  DENINICITY A PERCITATION AND A LOCATION OF DEATH  DENINICITY A PERCITATION AND A LOCATION OF DEATH  OCAN TO PRINCIPLE AND A LOCATION OF DEATH	
9a. FACILITY NAME (If not institution, give street and number)  9b. CITY, TOWN OR LOCATION OF DEATH  9c. COUNTY OF DEATH  9c. COUNTY OF DEATH	
DENINCIA DECIONAL MEDICAL COMPEN	nu .
PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO	
10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INS	DE CITY
LIM	TS?
	8 2 NO
10. ZIP CODE 10g, CITIZEN OF WHAT COU	NTRY?
30596 Pineknoll Drive 21853 U.S.	
1 Never Married 2 Married FORCES? 1 YES 2 Morried FORCES, 1 Yes September 1 or No. 14. RACE — American FORCES, 1 Yes September 1 or No. 15. White, e Black, White, e	can Indian, Ic.
3 Windowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 WO Specify: Whit	
THE PERSON NAMED AND ADDRESS OF THE PERSON NAMED AND ADDRESS O	е
(Shecitly only highest grade completed) (Give kind of work done during most of working	
Consider (1-4 Ot 2+)	
7 Homemaker	
17. FATHER'S NAME (First, Middle, Last)  18. MOTHER'S NAME (First, Middle, Maiden Surname)	
Martin F. Willing Mamie V. Tyler	
19a. INFORMANT'S NAME (Type/Print)  19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Mrs. Anne Tapman 30596 Pineknoll Dr., Pr. Anne, Md. 2	1853
206. METHOD OF DISPOSITION 206. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State	
Commetted   2   Cremetted   3   Removal from State   Commettery, Cremettery, Cremettery or other place)   St. Johns Cemetery   3/25 Deal Island,	Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY	
Hinman Funeral Home	
Ama & Munner ( M00295   Princess Anne, Maryland 21853	
	proximate erval Between
IMMEDIATE CAUSE (Final	set and Death
a. Acute Myocardial Infarction with Complete Av block  Due to (or as a consequence or):  E Cardusgenic Shield	
DUE TO (OR AS A CONSEQUENCE OF): & Cardusence Shock	
A 1	
Athenselvasic	
Sequentially list conditions, if any, leading to immediate  DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING  b. Attendersis  DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate  DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. Atheroclessis  DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  24b. WAS AN AUTOPSY  24b. WERE AUTOPSY  24c. WAS AN AUTOPSY  24b. WERE AUTOPSY  24c. WAS AN AUTOPSY  24c. WAS AN AUTOPSY  24c. WERE AUTOPSY  24c. W	TOPSY FINDINGS
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  24b, WERE AU  PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I.  PERFORMED?  ANALABLE  COMPLET	E PRIOR TO ION OF CAUSE
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  1	E PRIOR TO ION OF CAUSE I?
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  1	E PRIOR TO ION OF CAUSE
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IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

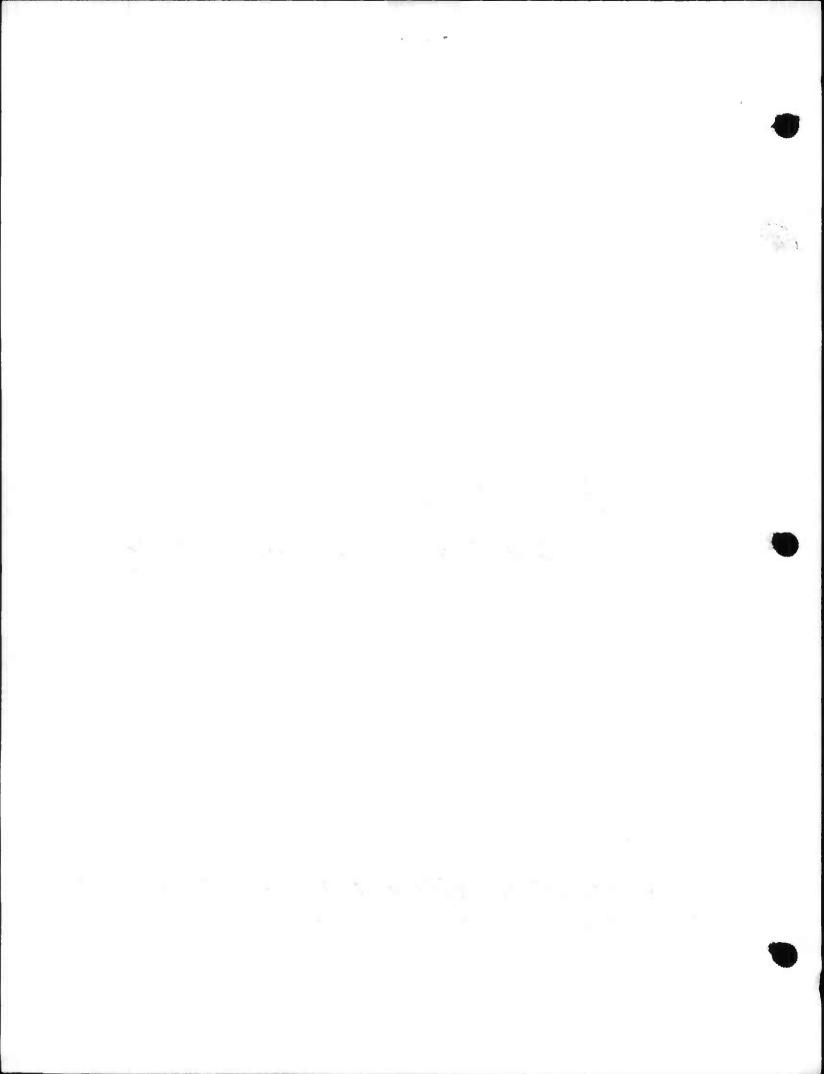
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

20 miles 20 Miles 284

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 . Lins after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache he filed within 72 hours after death with the State Debt, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
ithin 24 arts afte	letely filled in by the emation, or remove	nt, the medica	
ate be executed wi	ysician and compli prior to burial, cre	traumatic ever	
he death certification	the attending ph Mental Hygiene	njury, or other	
w requires that t	been signed by pt. of Health and	3 shows any i	
YSICIAN: The la	s certificate has ith the State De	ed, or item 2	
ATTENDING PH	RECTOR: After this after death w	m 28 is marke	
THE HOSPITAL OR	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fire within Z hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If Ite	
p-m		0010	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL	HYGIENE REG. NO.
	2. DATE O	F DEATH

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH 3. TIME OF DEATH				
	Lillian Held	en Bowie				03-28-9	93	1:30 pm			
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (	(In yrs. last birthday)			7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)			
i	387-26-4977	1 🗆 M 2 💢 F	74 YRS.	MONTHS DA	YS HOURS MIN.	09-05-1	1918	Michigan			
	9a. FACILITY NAME (If not institution, give s	treet and number)		9b. CITY, TO	WN OR LOCATION OF DE	EATH	9c. COUN	ITY OF DEATH			
8	Rt 1 Box 1210			La	Plata		Cha	arles			
DIRECTOR	RESIDENCE OF DECEDENT  10a, STATE  10b, COUNTY	,	10c Cl	TY, TOWN OR L	OCATION			10d. INSIDE CITY			
<u> </u>								LIMITS?  1 YES 2 NO			
	10e. STREET AND NUMBER	.105	<u>a Pla</u>	101, ZIP CODE		10g. CITIZ	ZEN OF WHAT COUNTRY?				
	Rt 1 Box 1210						US	34			
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER II			20646 DECENDENT OF HISPAN			14. RACE — American Indian.			
L	1 Never Married 2 Married	FORCES? 1 YES	ATES		s, specify Cuban, Mexica YES 3/5/NO Specify			Black, White, etc.  Specify:			
8√	3 🔀 Widowed 4 🗌 Divorced				7.77		White				
COMPLETED	15. DECEDENT'S EDU- (Specify only highest grade		18a. DECEDENT'S (Give kind of life. Do NOT	work done durin	PATION g most of working	16b. KIND OF	BUSINESS/IND	USTRY			
ן ב	Elementary/Secondary (0-12)	College (1-4 or 5+)		Make	r	ם .	ome				
	17. FATHER'S NAME (First, Middle, Last)		1101110	rianc		ME (First, Middle, Maid					
	Frank Gayon				Anna		on ourname,				
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILIN	G ADDRESS (St	reet and Number or Rural		Town, State, Zip	Code)			
2	Sylvia Sewell		2510	Lorr	ing Dr.	Distric	t Hei	ights,MD 2074			
1	20a METHOD OF DISPOSITION XIX Burlat 2 Cremetion 3 Rem	201			of cemetery, crematory or			City or Town, Stata			
į	4 Donation 5 Other (Specify)	Tr	cinity	Memor	ial Gard	ens Wa	aldorf	E, MD			
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	1 _		E AND ADDRESS OF FA		oro1	Home, Inc.			
	1 Jacoton	C. Leho	TH	P.	O. Box 5	nois rui 67 LaPla	ierar ita. N	1D 20646			
	23. PART I. Enter the dispases, or o							est, Approximeta			
i	IMMEDIATE CAUSE (Finel	List only one cause on e	ech iina.		11 11		1,	Onset and Dasth			
	disease or condition resulting in desth)	Lung	Caure	1 hrs	H 7	tour	140	18			
		DUE TO (OR AS A CONSEQUENCE OF):									
N O	Sequentially list conditions,	Sequentially list conditions,  DUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	If any, leading to immediate csuse. Enter UNDERLYING	DOE TO (OR AS )	CONSCOUENCE	ury:				i i			
윤	CAUSE (Diseeae or injury that initieted events	DUE TO (OR AS /	A CONSEQUENCE	OF):							
H	resulting in death) LAST	d									
_	PART II. Other significant condition	a contributing to death !	out not resulting	In the under	dvina cause alven in	Part I 24s was	AN AUTOPSY	24b. WERE AUTOPSY FINDINGS			
Z	The state of the s		or not resulting	in the onder	rying cause given in	PERI	ORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE			
MEDIC						1 ( YES	2   NO	OF DEATH?			
								1 TYES 2 NO			
A	25. WAS CASE REFERRED TO MEDICAL	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)									
SIC	EXAMINER? 1 YES 2 NO	HOSPITAL: OTHER:									
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	26b. TI	ME OF 28	L INJURY AT WORK?	28d. DESCRIBE HO	W INJURY OCC	CURED			
>	1 Natural 5 Pending 2 Accident Investigation	1 Natural 5 Pending M 1 YES 2 NO				l					
0 8	3 Suicide 8 Could not be 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28f. LOCATION (Street City or Town, State						and Number or Rural Route Number,				
ETED	4 Homicide determined										
29a. CERTIFIER (Check only  CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.								1			
COMPLE	One)  MEDICAL EXAMINER: On the beals of examination and/or trivestigation, in my opinion, death occurse at the time, date and place, and due to the cause(s) and menner as										
BE	29d. DATE SIGNED (Month, Day, Year)										
0	V X W	14/11/	y evel	aug	10-2	4535	-0	5-30-42			
	LAXMI BerwA M.D. 7700 Old Branch Ave CIOI Clinton nd. 20735										
	31. DATE FILED (Month) Day 193	Julia Davido	n-Handell	-							
- 1											



John R.

31. DATE FILED (Month, Day, Year)
MAR 0 3

Smith,

93

Jr., M.D.,

32. REGISTRAR'S SIGNATURE

		6	
BALTIMORE, MARYLAND 21215-0020	hat the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician.	I by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit arms and Mental Hvolene only to burial, cremation, or removal.	in in the trumple event the medical examiner must be notified at once
RDS, P.O. BOX 68760,	hat the death certificate be executed within 24	I by the attending physician and completely filled in by the fune and Mental Hydiene order to burial cremation, or removal.	v injury or other traumatic event the

										93	10	1000		
	1 - STATE REGISTRAR	STATE OF MAI		ARTMEN					IENE . NO.		11:0	)Opm		
	1. DECEDENT'S NAME (First, Middle, Lest) 2, DATE							2. DATE OF DEA	OF DEATH 3. TIME OF DEATH					
- 8	James Hall Bar	ton, Jr.						Februar		1993	11	PM		
- 8	4. SOCIAL SECURITY NUMBER		AGE (In yrs. last birtho	rs. Inst birthday) IF UNDER 1 YEAR IF UNDER				DS 7 DATE OF BIRTH			PLACE (State	e or Foreign		
	220 - 28 - 4914	1 (XM 2 () F	64 YR	YRS. MONTHS DAYS HOURS MIN.				May 17,	1928	Mar	Maryland			
	Sa. FACILITY NAME (If not institution, give stre	TY NAME (If not institution, give street end number)  9b. CITY, TOWN OR LOCATION OF DEA								UNTY OF D				
Œ	Hope Road, P.O. B	ox 222		Cen	trev	ille			Queen Anne'					
5	RESIDENCE OF DECEDENT					_								
TED BY PHYSICIAN: MEDICAL CERTIFICATION TO BE COMPLETED BY FUNERAL DIRECTOR	Maryland Ouee	Centreville 10d. INSIDE CT X LIMITS?								37				
	10e. STREET AND NUMBER				10	. ZIP COD	E		10g. C	VHAT COUNT	TRY?			
B/	Hope Road, P.O. B	ox 222				216	17		Un	United States				
N.	11. MARITAL STATUS	12. WAS DECEDENT EV	VER IN U.S. ARMED	RMED 13. WAS DECENDENT OF HISPA				NIC ORIGIN? (Spec	Ify Yee or No	14 BACE	- America	n Indian		
	1 Never Merried 2 N Merried	FORCES? 1 I	YES 2 NO		If yes, sp		in, Mexica	in, Puerto Rican, el			E — Americe k, White, etc.			
	3 Widowed 4 Divorced					2 65 110	Opeon	,		Wh	ήγ: ite			
ED	15. DECEDENT'S EDUCA (Specify only highest grade of		16a. DECEDE	T'S USUAL	OCCUPATION	ON		16b. KIND (	F BUSINESS/II	NOUSTRY				
E	Elementary/Secondary (0-12)	College (1-4 or 5+)	Me. Do M	d of work don OT use retired.	)		ng							
1	11	5	Licens	ed Mo	rtic	ian		Mort	uary S	ciend	e			
O	17. FATHER'S NAME (First, Middle, Last)							ME (First, Middle, A						
ш								Florence	Murr	ay				
m	19e. INFORMANT'S NAME (Type/Print)	Wife						Route Number, City						
۲	Marion M. Barton Hope Road, P.O. Box 222, Centreville, MD 21617													
	20e, METHOD OF DISPOSITION 1 \( \text{Label And OATE OF DISPOSITION (Name of cemetary, crematory or other place)} \) 20b. PLACE ANO OATE OF DISPOSITION (Name of cemetary, crematory or other place)													
	1 A Burdal 2   Cremation 3   Removal from State   of cemetary, crematory or other place)   Chesterfield Cemetery   Centreville, MD													
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY													
	John R. Merceron Newnam Funeral Home													
_	JOHN T. MERCERON CEST 200 S. Harrison St., Easton, MD 21601													
	23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between													
	IMMEDIATE CAUSE (Finel				1	10					Onse	et and Death		
	disease or condition resulting in death) e.										2	you +		
		DUE TO (OF	AS A CONSEQUEN	CE OF):								0		
Z	Sequentially list conditions b.													
E	If any, leading to immediate													
2	CAUSE (Disease or Injury	inter UNDERLYING												
F	that initiated events	OUE TO (OF	AS A CONSEQUEN	E OF):										
EH	resulting in death) LAST													
O	PART II. Other significant conditions	contributing to da	ath but not result	ing in the	undarivin	a cause	alven in	Part I. 24a. W	AS AN AUTOPS	Y 24t	WERE AUTO	OPSY FINDINGS		
S	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							P	PERFORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE			
ă	16.								1 TYES 2 NO OF D					
Z											1 TYES	2 NO		
ż														
ਰੋ	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  HOSPITAL:  OTHER:													
YSI	1 TYES 2 NO	1  Inpatient 2 E	R/Outpatient 3 D		ursing Hor	ne 5 R	lesidence	8 Other (Speci	'y)					
D BY PHYSICIAN: MEDICAL CERTIFICATION TO BE COMPLETED BY FUNERAL DIRECTOR	27. MANNER OF DEATH	28a. DATE OF IN. (Month, Day,		TIME OF		JURY AT DRK?		28d. OE\$CRIBE	HOW INJURY	OCCURED				
	2 Accident Investigation	1 Natural 5 Pending M 1 YES 2 NO												
0	3 Suicide 6 Could not be 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify)							28f. LOCATION ( City or Town		ber or Rural	Route Numbe	M,		
Ш	4 Homicide determined													
ZE.	29e. CERTIFIER (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.													
ME	(Check only one)  2   MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occured at the time, date end place, and due to the ceuse(s) and manner as stated.													
	296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Morth, Day, Year)													
Ш	The state of the s	1 : 1	V			ZWC. LIC	ENSE NU	2 11 E	290.0	ALE SIGNE	(Month, De)	(, rear)		
1 - F 1. DEC 1.														

Centreville, Maryland

21617

